

# CONVENTION NUMBER

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JULY, 1917

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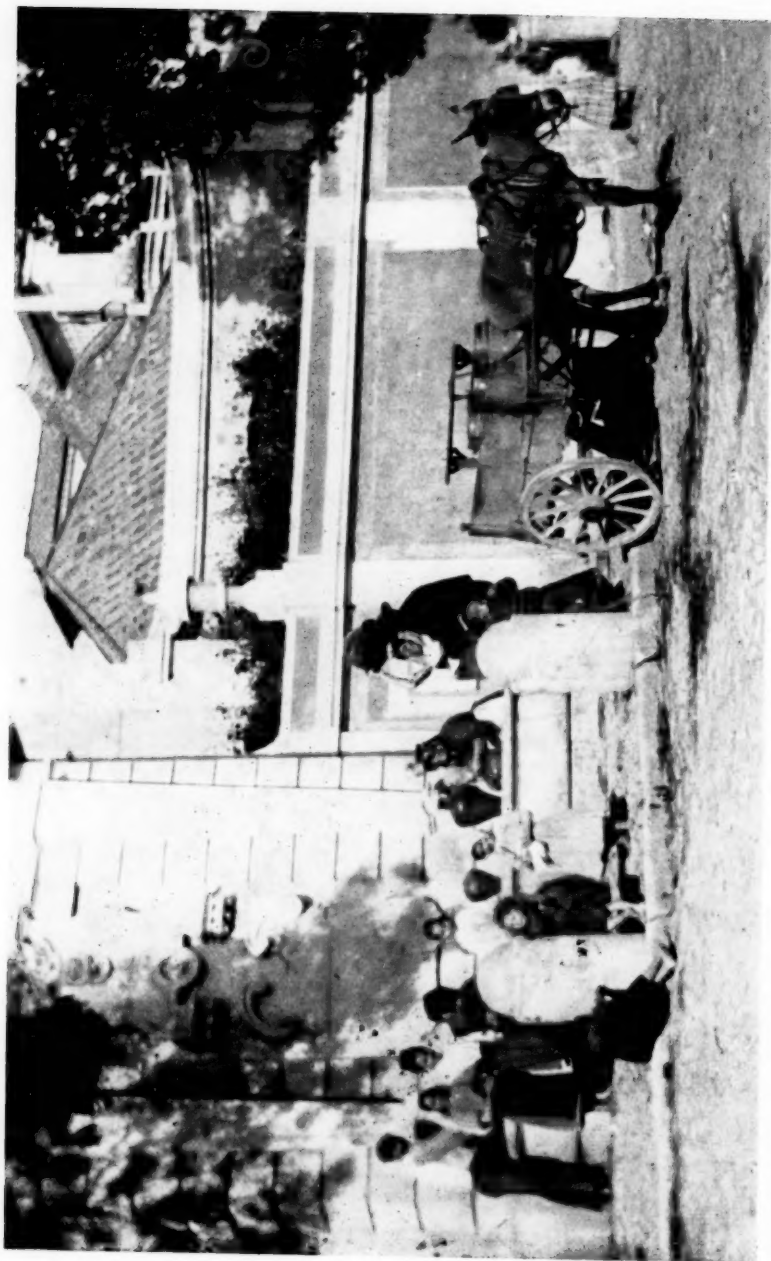
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THE FOUNTAIN IS THE PICTURESQUE MEETING PLACE OF WOMEN AND CHILDREN WHO COME TO FILL THEIR 'BILHAS'  
(See page 290)

# The Public Health Nurse Quarterly

VOL. IX

JULY, 1917

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## EDITORIALS

### PATRIOTISM AT THE NURSES' CONVENTION OF 1917

The first impression gained of the Nurses' Convention of 1917 was one of wonder that so many nurses could be brought together. The second impression, an intangible feeling of excitement, which was no mere emotional agitation, but when analyzed seemed the result of a stir of patriotism, produced by the troublous times and by the consciousness that large issues must be faced by the nursing profession as a whole and personally by each nurse present.

At every meeting this atmosphere of personal responsibility to the common cause of patriotism might be felt. It dominated the inspiring Red Cross meeting when the great audience filling the Academy of Music to the topmost gallery thrilled to the call of the wounded on the battlefields of Europe, and to the less dramatic, but no less insistent call of the lonely and neglected sick in our own remote country regions. To many, the first call came as an irresistible summons and they joyously dedicated themselves to the Red Cross, heedless of personal danger. The spirit of patriotism pervaded the meetings of the public

health nurses where the cry was constantly heard, "Our people need us as never before in these war times, and how are we to meet their need with depleted ranks?" This call to the public health nurses to remain at their posts is not one that can go unheeded. We have much to learn from the mistakes of Europe. The return of a conquering army to homes made desolate by the death of children must be prevented. Abnormal conditions create a greater susceptibility to disease, less resistance to the ills of life. Already in a number of cities the undernourished child is becoming a problem. France with her five hundred thousand cases of tuberculosis points a warning finger at possibilities. Certainly the convention made clear that a very real patriotism also calls the public health nurse to imperative duties at home,

Again the impulse of patriotism was to be felt at the meetings of the League for Nursing Education. Training school superintendents are being called upon to release their executives for foreign service and at the same time to nurse the sick in hospitals and to train the oncoming generation of nurses that they may be ready to meet the responsibilities so surely ahead of the nursing profession. The loyalty of the women performing these duties, whether as superintendents or in subordinate positions, cannot be doubted.

But it was not alone the meetings devoted to the Red Cross, public health nursing, and nursing education which were pervaded by this awakened spirit. Rich and poor are alike in their need when they become merely suffering human beings, and the private nurse caring devotedly and conscientiously for her single patient was made to feel that she too had her part to play in the preservation of national health. Nor was the nurse the only one affected by it. The women touching so closely the care of the sick through their service as managers and directors of nursing organizations thrilled to the common impulse, gaining a new stimulation from the meetings held for consideration of their special problems.

When at the end of those stimulating, inspiring, exhausting seven days, the eager throngs scattered, I think one question was on every lip. How can I best serve my country in this time of her trouble? The answering of this question must be to every nurse a serious duty and to the answer she must be God-guided. The convention of 1917 was the largest convention we have ever had. The papers were interesting and the discussions unusually helpful, but it is not for these reasons that it will long stand out from other conventions in our memory. It must so stand out because it was held in the year 1917, a year when it is a great and solemn privilege to be at work. It has served its purpose if all who were there feel impelled to a greater patriotism, a truer cruci-

fixion of all personal desires, and a willingness to work wherever and however they may be called to work.

MARY S. GARDNER.

#### THE VALUE OF DISCIPLINED SERVICE IN WAR TIME

Since the United States began to take an active part in the war it is more than ever apparent that the graduate nurses in this country represent an asset of peculiar value.

This is essentially a time when training and skill are at a premium in the estimation of all those who are trying to aid the country in making a sustained and adequate effort to reach the goal which it has set for itself. The idea that a person is more wholly capable if he exercises a trade as well as follows a profession was a familiar thought in the day when St. Paul made tents as well as interpreted the law; and the fact that a nurse is trained in manual service, as well as educated in the theory of her profession makes her able to serve in another sense from the person whose ideals have had no opportunity to be translated into practice.

In a certain sense the 100,000 or more graduate nurses in this country are already trained in a military sense. They are accustomed to watch faithfully at night while others sleep, to consider it, indeed, an unpardonable crime to fall asleep at their post; they are accustomed to make accurate records, to speak the truth without exaggeration, to live according to the laws of hygiene, to be punctual in keeping appointments and to be prompt in executing a command. They are taught to obey their ranking officers in the same way that soldiers obey. The system of the nurse's training is hierarchical in the same sense that the ecclesiastical and military establishments are hierarchical. In each system there is fear of penalty and respect for the authority vested in one's official superiors, together with a training which inculcates subordination of the individual to the work in hand.

Undoubtedly nursing education rests upon foundations deep set in the traditions of the Church; and the fact that obedience, subordination and respect for authority are prime necessities in those who give nursing care to the sick has undoubtedly had its part in retarding many of the plans for modernising or reforming the practices of nurses' training schools.

Whatever the reasons may be that account for it, the fact is that the 100,000 graduate nurses in this country represent an asset of such great value to a country which must lean heavily in war time on its reliable, responsible and efficient members, that we must make every

possible effort not only to see that they are wisely used, but that their number is maintained and increased. We must see the case as a general staff sees the problems of a regular army. Miss Nutting gives us timely warning that enough officers or teachers must be constantly reserved and protected for the important office of training new recruits, and these recruits must not merely be volunteers of a few weeks, they must be in large numbers persons who desire to become responsible and efficient nurses.

#### A DUAL VIEW OF WAR TIME PROBLEMS

For the benefit of all persons involved in the wide spreading desire to serve the country in new and unaccustomed ways, the coöperation between graduate nurses, nurse's aids and volunteers will have to be worked out according to definite and well considered principles. As a laywoman, I see very much that is good and very much that is dangerous in the sudden attempt which is being made to give short courses in nursing. To be sure, the greater part of all human material is in the hand of the untrained woman. She it is who, as wife and mother, makes or mars the health chances of hundreds of thousands of babies and young children; she it is who, because of her ignorance of dietetics, cooking, home making and the laws of health, keeps the mills of trouble grinding throughout the whole extent of civilized communities all the time; and she it is who now, in this moment of national stress, is eager and willing to learn things which could be of enormous value to the country and to the world at large if applied to her own home, or to the orderly supplementing of skilled service. All this I see from the laywoman's point of view, and therefore the need for the universal instruction of women in the principles of sanitation and hygiene.

But, on the other hand, the woman who has put in years of hard work for the purpose of acquiring a valid education in the principles and procedures of nursing, with a view to practising nursing as a profession, should be protected from the actual danger in which the haste and confusion of the present time may involve the whole question of nursing education. On all sides there must be forbearance, thoughtfulness and an unfeigned desire to do that thing which shall result in the greatest permanent value. We are glad that plans are being made which shall define unalterably such underlying principles as will safeguard nursing standards, while acknowledging the incalculable benefits which will follow even the partial training of the untrained woman. Only thus can we secure in the finest way the universal good that all are anxious to see arise from the great awakening which the love of country is bringing to us all.

## THE READJUSTMENT OF AVAILABLE NURSING STRENGTH

Not very long ago a financier of distinguished ability made a notable address before a group of persons which included in their number Cabinet officers and men of special executive ability now occupied in shaping the affairs of the nation to meet world-wide emergency needs. The dominating principle of his address was that luxuries of all kinds would have to be set aside in favor of those things which a world at war claims as necessities. He made it very plain that every bit of the human power now invested in the production of luxuries must be re-invested in the production of these necessities, and that such a rearrangement of work would not create hard times, but on the contrary would mean a great stimulation in work of all kinds. It would mean a readjustment of labor to fit the greatly increased recognition of these necessities for immensely larger numbers of people.

Now general principles such as these, if sound, can and must be applied to special problems. The 75,000 graduate registered nurses in this country must so invest their time as to yield the very greatest service to their country in its hour of need. Many of them must perforce stay at their original occupations, but all must do that work which is of the greatest use. The employment of the private duty nurse should in no wise be an exception to this rule. Her skill should count at its greatest value, and be made available for the largest possible need. It seems to us that a rich person ought not in these times of strain and dearth to tie up the services of a highly skilled nurse unless her *skill* is needed. If it is just a question of after care and agreeable "companioning" patient and nurse alike should be patriotic enough to see that the highly skilled woman must be making use of her skill. Her service should be too universal to remain a luxury. Of course, we must be moderate and reasonable in this as in all things, for no human being is able to work year in and year out at highest pressure and tension; nevertheless, it ought to be distinctly understood by all persons that luxuries, whether in the way of personal care, adornment, or the satisfaction of man's numerous super-wants, must be relegated for the time being to the pleasing realms of memory and that in war time, at least, the necessity and comfort of the many must be found somewhat at the expense of the luxury and indulgence of the few.

PRESIDENT'S ADDRESS TO THE NATIONAL ORGANIZATION  
FOR PUBLIC HEALTH NURSING

By MARY BEARD

It is with the greatest pleasure that I find myself called upon to welcome the members of the National Organization to this Fifth Annual Meeting.

No feature of an annual meeting is so pleasant or so profitable as this one of meeting each other and learning to know each other. Papers we can read at home, discussions we always have with us, but the personal acquaintance with the women doing the work of which we read and think, can come only through such meetings as these. The sense of belonging to each other and of being all of us a part of a great force capable of improving immeasurably the condition of our countrymen and women—is a very inspiring and a very delightful experience.

The everyday work is sometimes discouraging and heavy. The “thrills” do not come every day. This is one of the occasions when they *do* come, and the memory of it will be a source of pleasure to us all through the year.

You must let me begin by telling you what last year I had no opportunity to say—how very much I appreciate the honor you have done me in making me President of the National Organization. To do my best to deserve your confidence, is the first thought in my mind. It is no easy task to try to follow Miss Wald, our first President, and Miss Mary Gardner, our second—in this office, and if both were not at hand to advise and suggest, and if both had not been most generously ready to help in this way, the responsibilities would have seemed too great.

To us as an organization, the great good news of this year, is Miss Gardner's return to us. The publication of her book has come like a tangible expression of all the valuable experience of years—collected and digested and clarified by the enforced leisure, and even by the very distress and suffering of the past three years. To a very unusual degree, through this book, Miss Gardner has given to public health nurses the best of herself, and given it in a permanent form which will make her known and appreciated by many nurses who will never see her.

Miss Crandall will tell you how glad we are that Miss Lent is officially with us, but she cannot tell you with how much grateful appreciation any President of the National Organization must regard the services which she, herself gives the cause of public health nursing. Not one small degree of the enthusiasm of five years ago has left our Executive Secretary—not one moment has her devotion flagged. On the contrary, all her hard work during the difficult pioneer days of the National

Organization have increased that enthusiasm and devotion. Miss Crandall is known all over the country, and wherever she is known, she is loved and appreciated as she deserves to be. During this past winter, the Executive Committee has felt it wise for Miss Crandall to do less travelling and speaking, in order to concentrate from her office on some of the most recent developments in our organization work. To this policy, Miss Crandall has gladly conceded. Officially, and in public, let me say that Miss Crandall's attitude on this one point seems to me to have been a thing which demands our cordial recognition, for it is hard to wait and delay action when new demands for expansion are pressing upon us, and particularly when the opportunities are largely the result of Miss Crandall's own power to inspire and stimulate. The Executive Committee has already felt the good results of following this policy, and is confirmed in the wisdom of abiding by a plan which, except under unusual circumstances, will give us the services of Miss Lent in the office at those times when Miss Crandall is away, and will mean that Miss Crandall may be reached in New York while Miss Lent is away.

Not many days ago a message came to me from our Massachusetts Commissioner of Health, Dr. McLaughlin, asking me to use my influence to persuade public health nurses of the urgent need for their services at this critical time in the history of our country, *in their own line of work*.

He points out the abnormal conditions bound to exist at home during a state of war, and urges our responsibility to the cause of public health nursing at this time, to stay where we are and to turn the tide of public opinion, stirred now to an unusual sense of responsibility, towards a better industrial and social understanding—is this not our duty as public health nurses in this crisis?

Our impulse to enroll with out hospital units and go at the first call, will be controlled on sober second thought when our particular and special opportunity makes itself evident to us.

If we are doing our duty as public health nurses, we are serving our country every day. In these coming days that service is more than ever needed.

But if national affairs were not as they are the experiences of the last year have put new meaning into the work of public health nurses. I refer to the struggle for health insurance legislation. This struggle touches very closely the interests of public health nurses, and makes our chief value to the community shine out more than ever before. It is as an interpreter of the needs of the people that the public health nurse with her intimate, thirty years' experience of illness in American

homes of small means, brings to this great social movement, a power and force which will go very far to influence public opinion in the right direction.

The National Organization stands for this purpose of interpretation more than any one other. Having written that last sentence, I must justify it in your judgment and my own, by reviewing our "reasons for being," and putting them in order for inspection.

1. The National Organization desires to find out how best and most effectively to do its work (and it is a five-branched candle-stick that must bear on five candles of public health activities: bedside, baby, tuberculosis, school, and industrial nursing) and having collected all our experience for this purpose, the National Organization will publish results:

- (a) Through our Executive and Associate Executive Secretary.
- (b) Through our QUARTERLY.
- (c) Through our Bulletin.
- (d) Through our publicity methods in general.

2. We will not impose any one method anywhere—the nature of our organization forbids this—but we will collect, compile, analyze, and present faithfully, in order that all our members may know what each is doing.

We do not impose or insist. We demonstrate; we spread forth; we suggest several points of view. Unless the National Organization can interpret the public health nursing movement itself, to the communities calling upon it, it cannot hope to develop any uniform standard. This brings me to an expression of appreciation for the work of the standing committees and of the lay and nurse representation in the different states. Through them comes the record of the work actually in progress, and colored and influenced by many local conditions.

So we have struggled to perfect record systems in order that we may be able to make reports to the public which will truly and exactly interpret the needs we see. In our ability to accomplish this, lies the test of our systems. And not only by means of studies and reports are we called upon to help in this cause, but upon us must rest the great task of determining what adequate nursing care will mean under the act and how such nursing care can be administered.

Once more let me say that the National Organization stands or falls chiefly on its ability to succeed as an interpreter of the public health needs and facilities of a community.

Ours is the only one of the three national nursing associations having lay membership. This is because in our work lay people have an equally important part with nurses, and to both lay and nurse interests the value of exact and full interpretation became a necessity.

As bedside nurses we see and feel the distress in homes where there is sickness, and not money to meet its cost. We must interpret this knowledge and this emotion to our boards.

The industrial nurse finds her chief value in her office of interpreter between workers and management. The school nurse, between teachers, mothers and the school board.

Health insurance has made us realize how far-reaching and widespread this function of interpreter must become.

We must set our house in order against the day when nursing under health insurance acts will be ours to administer.

First, local communities must be representative and well informed, and then a well-organized nursing unit must be so conducted as to be available to all the people of a community, and desirable to all. The District Nursing Association in Providence, Rhode Island, shows an example of such a unit managed efficiently on the basis of specialized services in public health nursing—while Dayton, Ohio, shows another in which the generalized system seems most effective. Whatever methods we take to reach the end, the end is the same.

One duty is clear. We must no longer allow our light to be hidden under a bushel. We must interpret ourselves to the public, and to do this, we must respect and study and make use of publicity methods—just as every successful business concern is doing.

Today we may say with an air of assurance *public* health nurses, for the public has accepted us to a greater degree than we could have believed possible five years ago. The future is big with promise. It demands of us a faith in the methods we have tried and proved, and a determination to interpret that faith into such a creed that he who runs may read it.

## NOTES ON THE HIGH LIGHTS OF THE 1917 CONVENTION

By M. JOSEPHINE SMITH

The meetings of the National Nurses' Convention of 1917 were arranged on a plan which differed somewhat from that of former years, in that the sessions of all three organizations were held together; subjects of mutual interest were considered and usually one paper was contributed by a member from each association; while opportunity for discussion was provided by separate round tables following the joint sessions. In these notes an effort is made to gather up the main points brought out at the meetings, as they refer to the public health nursing group only; but throughout this Convention Number of the *QUARTERLY* footnote references are made to papers which dealt with the subjects

from the standpoint of the two other organizations, stating where they are to be published.

Philadelphia's warm-hearted welcome to the national nursing organizations was rendered notable by the fact that it was participated in by the municipality and a large number of official and unofficial organizations, which extended a gracious and generous hospitality to the assembly. The social hour each afternoon on the roof garden of the Bellevue-Stratford made a delightful pause in the midst of the day's toil, and there was much appreciation of the kindly hospitality which provided afternoon tea for these gatherings.

The presence of a large number of lay members added stimulation to the meetings, especially to those on Organization and Administration. Each succeeding year the National Organization for Public Health Nursing becomes more fully aware of the great benefits which accrue to it through the close and constant coöperation of its lay and nurse members. The value of this composite membership stands out with ever-increasing emphasis at the annual meetings of the organization, and goes on record with greater definiteness in the minds of all the members. The incalculable variety and extent of this kind of coöperation is one of the surest guarantees which we possess of reaching the successive goals of our aspiration and desire.

The New Orleans Convention brought out certain clearly defined plans for the future work of the National Organization for Public Health Nursing. These plans were the result of efforts and experience covering several years, upon which it was possible to found an outline of the direction which the activities of the organization should take during the succeeding year. The work of the past twelve months, therefore, has been largely that of experiment and progress along these lines; and the Philadelphia meeting is to be measured from this standpoint, rather than from that of the presentation of new plans and a further formation of policies. With this in mind, it should be both interesting and instructive to point out, as far as possible, in the report of the 1917 Convention, what progress has been made in respect to the recommendations of the 1916 meeting, as well as to note any new direction of effort for the ensuing year.<sup>1</sup>

#### EXTENSION OF VISITING NURSING SERVICE

At the meeting in New Orleans consideration was given to the development of visiting nursing service in such a way as to bring skilled

<sup>1</sup> See "Notes on the High Lights of the Convention," *QUARTERLY* of July 1916.

nursing care within reach of all those requiring such care; and discussion was also devoted to the relation of the graduate nurse to the partly trained or untrained attendant.

During the past year a system of hourly visiting nursing service, at cost price, has been attempted by various associations, and in Cleveland and Providence the plan has been worked out with considerable success. The demand for this pay service has been largely in the direction of maternity service and nursing care at the time of delivery, which obviously necessitates night calls, and a special Round Table on Night Nursing was held. The system in Cleveland was described, which includes care at the time of delivery, limited instruction and supervision during the pre-natal period, and the provision of attendants to remain in the homes, when necessary.\* The need for this type of nursing care is strongly evidenced, and the many difficulties in the way of meeting it are being overcome in at least two cities, while others are making serious efforts to meet them.

The necessity for the development of some form of supervised attendant service has been demonstrated in connection with the extension of visiting nursing care; and in view of the imminence of health insurance it has become a question of grave importance to the nursing profession generally; for the extension of sickness benefit provided by the Health Insurance Acts now under consideration will be so great that it will be impossible for the professional women of the country to meet it, unless they are prepared to supplement their own highly skilled work with the less skilled service of trained attendants. If they are not prepared to do this, there is very serious danger that the matter will be taken out of their hands, and that the nursing care provided by the law will be given by women who have neither the requisite professional training nor the readiness nor ability to recognize their own limitations. So important has become the question of providing supervised attendant service that a joint session was devoted to the subject of the "Training and Status of Attendants," to which papers were contributed defining the need for another class of sick attendants besides the nurse, and discussing plans for their training and the regulation of their work. It was pointed out that the need for a sick room helper was perceived in England as early as 1889, and the reasons which at that time made it appear a poor policy to try to combine in one person highly skilled work and ordinary manual toil are infinitely more im-

\*A paper describing this service appeared in the *QUARTERLY* of January 1917, under the title of "Organized Neighborhood Nursing."

pressive at the present moment, when the strictest conservation of every kind of energy is of such vital importance.<sup>2</sup>

While no new recommendations were offered by the Round Table on Visiting Nursing, there was very interesting discussion of a number of practical problems, of which one of the most important was that of the advisability of carrying on contagious disease nursing in connection with general work. Many associations and nurses reported that they were doing this successfully; and a special round table was held for the consideration of modern methods of communicable disease nursing, the principles of which are so clearly laid down in the paper presented by Dr. Goler at the Joint Session on "Modern Demands on the Graduate Nurse."<sup>3</sup>

It was the unanimous feeling of the committee that actual bedside nursing is essential to good, all-round public health work, because of its immediate effect on the patient and his surroundings, and its influence in gaining the confidence of the family.

#### THE EXTENSION OF PRE-NATAL NURSING

At last year's meeting the importance of pre-natal nursing was discussed at a Round Table on Metropolitan Nursing, in connection with the extension of this service to include two pre-natal visits to expectant mothers; and at that time a strong feeling was expressed that, in order to be effective, pre-natal visits should be made at least every ten days.

At a round table for supervisors in the Metropolitan Nursing Service satisfaction was expressed with the excellent results which had been obtained through the pre-natal visits, which had not only afforded opportunity to give instruction to expectant mothers regarding their own care, but had also made it possible to insure proper medical attention for a greater number of maternity cases.

The great importance of pre-natal nursing was strongly emphasized at the Session on Maternity Nursing, and a paper by Dr. Edward P. Davis gave some startling mortality statistics in regard to diseases caused by childbirth, and the terrible wastage of the lives both of mothers and infants for the want of proper knowledge and care.<sup>4</sup> This

<sup>2</sup> A paper by Edith M. Ambrose on "How and Where Should Attendants Be Trained?" is published in this issue of the *QUARTERLY*. A second paper from this Session, by Frances Stone, on "Is There a Need for Another Class of Sick Attendants Besides Nurses?" will be published in the *American Journal of Nursing*.

<sup>3</sup> Dr. Goler's paper is published in this issue of the *QUARTERLY*.

<sup>4</sup> The paper by Dr. Davis is published in this issue of the *QUARTERLY*.

need was further pressed home by Dr. Grace Meigs, of the Federal Children's Bureau, who spoke especially of the situation of women in the rural districts.<sup>5</sup> Many of these expectant mothers, living often in isolated regions far from both physician and hospital, have appealed to the Federal Bureau to provide help and care for the time of their need, describing the dread with which they contemplated the future, because of their knowledge of the terrible experiences of others in their condition. The provision of county units for maternity service is looked forward to as a logical solution of this problem in the rural districts, and preparations are being made for their development.

#### HEALTH INSURANCE<sup>6</sup>

The whole of a joint evening session was devoted to the subject of Health Insurance, and papers were presented by Miles M. Dawson, Pauline Newman and I. M. Rubinow.<sup>7</sup> A Round Table was also held for discussion of the subject, and nurses were asked to watch carefully in their own states the wording of the bill regarding the provision of nursing benefits; it was pointed out that the bill in each state should mention the actual name of the State Nurses Association as being the responsible body to appoint the Advisory Council to be consulted on all nursing matters.

#### THE EDUCATION OF THE PUBLIC HEALTH NURSE

It was generally accorded that probably the greatest accomplishment at the New Orleans Convention was the unanimous acceptance by the League of Nursing Education of the introductory course in public health nursing prepared by the Committee on Education of the National Organization for Public Health Nursing.

At the Philadelphia meeting, preparation of students for public health work was linked up with the whole question of nursing education and the work of the training school and hospital. How and when such preparation can best be given was considered in several papers contributed to different sessions, and certain practical aspects of the subject were more particularly discussed by Miss Gardner, in a paper

<sup>5</sup> The paper by Dr. Grace Meigs on "County Units for Maternity Service," and that by Maude S. Smart on "Opportunities of the Prenatal Nurse in Connection with Venereal Diseases and Prevention of Blindness" will be published in the *American Journal of Nursing*.

<sup>6</sup> See the paper by Miss Beard in this issue of the *QUARTERLY*, and that by Mr. Dawson in the *QUARTERLY* for April 1917.

<sup>7</sup> To be published in the *American Journal of Nursing*.

which is published elsewhere in this issue of the *QUARTERLY*.<sup>8</sup> It was also brought out that hospitals and visiting nurse associations offering public health nursing experience should be urged to confer with the centres already successfully doing this work, in order that somewhat uniform opportunity may be afforded to students in training.<sup>9</sup>

The efforts of the Committee on Education during the past year have been largely devoted to the consideration of standards for post graduate courses in public health nursing, and a strong feeling was expressed that, although it is not always possible to have such courses conducted by the University, this should be done whenever practicable—not only because the University ensures the best kind of equipment for the conduct of the course, but also because it is of considerable value to the student to have this contact with the University.

The question of whether women who have received special training only, without nursing training, should be permitted to enroll in the public health nursing courses in preparation for public health work in special lines, was considered; and the belief was expressed that it would be dangerous to admit such students, and that the post graduate work should only be open to those who have received the necessary professional training.

#### PUBLIC HEALTH NURSING ORGANIZATIONS AND AFFILIATION WITH WOMEN'S CLUBS

It will be remembered that one of the most important resolutions of last year's convention was that addressed to the National Federation of Women's Clubs, by which a closer association and coöperation on the part of women's clubs and nursing organizations was sought. A very interesting development in this direction was reported at the meeting of the Council of State Representatives, in the form of an offer by the President of the National Federation to present to the federation at its next meeting a recommendation from the National Organization that public health nursing should be included on the national program of subjects to be taken up by clubs during the year. In this way, every club in the Federation would automatically arrange for a talk by a public health nurse as a part of its year's program. A motion was passed recommending that this offer be accepted.

<sup>8</sup> "How Can the Small Hospital Train Pupils Toward Public Health Nursing?" Mary S. Gardner.

<sup>9</sup> The National Organization will be very glad to discuss such a plan with any board desiring information.

## MEETING OF THE COUNCIL OF STATE REPRESENTATIVES

During the past year a Council of State Representatives has been formed as one of the activities of the National Organization; this council is to be composed of two representatives from each state, one a nurse and the other a lay woman. Representatives have already been appointed in many states and there was quite a large gathering at a meeting of the council held to discuss future plans. During the brief period of its organization, members of the Council have taken various steps with a view to becoming better acquainted with the nursing needs and possibilities in their respective states; public health nursing associations and public health nurses have been listed, and efforts have been made to obtain the interest and help of women's clubs.

If public health nursing is placed on the program of the National Federation it will be the duty of the state representatives to provide speakers for the various clubs, and in order to do this to the best advantage it will be necessary to discover the need of each particular community and to arrange for a talk which will focus along the lines of that need. The suggestion was made that the National Organization should formulate, for general distribution, a set of simple questions and directions which would enable any community to discover its own conditions and needs: because experience has shown that the first question always asked of those who try to promote public health nursing in a community is, How can we tell if a public health nurse is needed? It was interesting to know that a recommendation along these lines had previously been made by the Russell Sage Foundation. It was explained that usually the nurse representative had been chosen because she knew her own state very well and some phase of the nursing situation very well, and it is hoped that she may be a means of communication with the State Department of Health and with many other agencies and may gain their active coöperation—in a broad sense, it will be her duty to interpret the National Organization to the lay people of her state. It was felt that if she could demonstrate a definite need, or better still, help people to discover their own need, it could then be known that she had done this on behalf of the National Organization and intelligent interest in the organization would be aroused.

The discussion showed that the methods of creating interest would have to be varied in accord with requirements and experience in different states. A definite call, such as that of Health Week, or Baby Week had been found very helpful in some instances; various kinds of exhibits could be used, sometimes with a good deal of success; and talks and demonstrations to fit the local conditions should be provided.

The work of the state representatives is to be two-fold: to arouse general interest in public health nursing, and to promote interest in the National Organization. The former naturally comes first, because the policy of the National Organization is not to seek to impose itself upon a community, but rather, through the creation of intelligent interest in local conditions, to bring about a demand for assistance and direction in remedying what is wrong; and the Organization then becomes the natural agent for supplying this help and direction. While the first and principal point of interest is naturally that of providing nursing care for the sick poor, this foundation should, in due course, lead to a more intelligent interest in the prevention of sickness; and it is hoped that club women and, by degrees, the public generally, will come to concern themselves with nursing as a profession and in the education and standards upon which it rests. This, in its turn, will help to increase the supply of public health nurses in response to the rapidly increasing demand.

Thus, the general trend of the meeting seemed to point to three specific ways in which the state representatives can be of help to the organization.

1. By having local inquiries into conditions made, preferably by the people themselves, with the guidance of the nurse representative and her help in interpreting the findings.
2. By creating a demand for the improvement of bad conditions, which will lead to requests for assistance and direction being brought to the National Organization, through its state representatives.
3. By promoting the interest of women's clubs and the general public in nursing as a profession, and thus helping to increase the supply of public health nurses to meet the demand.

#### THE STANDARDIZATION OF RECORDS, STATISTICS AND REPORTS<sup>10</sup>

Last year the report of the Committee on Records and Statistics recommended the adoption of a general standard record card embodying the ten points of vital statistics required by the Organization.

At the Round Table on Infant Welfare at the 1917 meeting a standard card for infant welfare work was passed upon, which had been approved by Miss Julia Lathrop and Dr. Grace Meigs, of the Children's Bureau, as containing the information desired by the Bureau; and which in addition contained the ten points of vital statistics required by the National Organization. It was suggested that

<sup>10</sup> The papers from the Session on "The Relation of Clinical Records to Vital and Morbidity Statistics" will be published in the *American Journal of Nursing*.

a committee of the National Organization should confer with representatives of the American Public Health Association and the American Association for the Prevention of Infant Mortality, which are considering the standardization of records. It was also moved that the method of admitting and discharging babies from the clinic or health centers should be referred to the Committee on Standardization.

The industrial nurses also passed upon a record card which had been remodeled by the Committee on Industrial Nursing, and which covers the need of the industrial nurse whose duties combine home visiting and the consideration of social conditions. The committee was further asked to consider outlining a card for use by those nurses whose work is largely that of first aid and in the dispensary, and a sub-committee was appointed to pass on the question as to whether the cards meet the requirements of the employers, insurance, and compensation.

At the Round Table on Organization and Administration the recommendation was made that there should be some standardization of administrative cost. This can only be accomplished through the adoption of a uniform method of keeping and presenting accounts. A standard form for financial statements was presented by Miss Gardner; and it was moved that a special committee be appointed, whose duty it should be to have ready, by January 1 next, a form of financial report that can be used by all visiting nurse associations. This recommendation was referred to the Executive Committee.

At the Round Table on Statistics and Reports the method of using stenographers for the record work was described. This is done in Cleveland, and has resulted in great saving of time on the part of the nurses; as well as in better keeping of records. It was the general feeling of the meeting that, wherever such a method is practicable, it would be highly desirable to make use of it. The value and use of records was emphasized, and some striking examples were given of accomplishments which had been made possible by the intelligent study of statistics and the practical application of the lessons which they teach.

#### PUBLIC HEALTH NURSES AND THE MENTAL HYGIENE MOVEMENT

The interest aroused in mental hygiene at the 1916 Convention was again evidenced this year, and at the Round Table on Mental Hygiene it was brought out that the public health nurse has the greatest opportunity to assist in the prevention of mental disease. Both at this meeting and at the joint session on "Some Modern Demands on the

Graduate Nurse," at which a paper on the subject was presented, the necessity for training, especially in regard to the recognition of early symptoms, was emphasized;<sup>11</sup> it was also pointed out that much help and coöperation can be given by Societies for Mental Hygiene, to those nurses who are able to get in touch with them.

#### PROBLEMS OF THE RURAL NURSE

Last year the emphasis at the meetings on rural nursing was laid upon the position of the public health nurse in regard to the giving of material relief. The difficulties in regard to this question are still found to be very real in many rural communities where there is no social worker; but stress was again laid upon the fact that every effort must be made to have this work carried on by some individual or group other than the nurse. A feeling was also expressed that patients should be required to pay for the services of the nurse whenever possible.

One of the principal difficulties met with by the rural nurse is that of obtaining the coöperation of the physicians in her community. It was unanimously felt that the coöperation of the doctors was absolutely essential and that every means must be used by the nurse in order to obtain it. It was pointed out that this difficulty was sometimes caused by the fact that the physicians had not been consulted as to the necessity for the appointment of the nurse nor had her functions been explained to them, as quite often she is engaged without any consultation with the physicians of the community. A resolution was passed to the effect that a committee should be appointed to formulate a letter to be sent by the National Organization to the State Medical Associations, requesting that duplicate copies accompanying the letter be sent to all County Medical Societies within the state; the said letter to explain in what way the coöperation of physicians could further the usefulness of the public health nurse as it relates to the care of the sick, the health of school children, work with mothers and babies, and other duties of the public health nurse.

#### INDUSTRIAL NURSING

Two recommendations were offered by the industrial nurses, as follows:

"That we as nurses should not undertake industrial nursing when there is not a physician representative for medical care of employees."

<sup>11</sup> A paper on "Mental Hygiene" by Jessie Taft, contributed to the Joint Session on "Modern Demands on the Graduate Nurse," will be published in the *American Journal of Nursing*.

"That the Executive Committee of the National Organization next year request the American Nurses' Association for a joint session on Industrial Nursing, and that it be not put on the first day of the convention."

#### HOSPITAL SOCIAL SERVICE<sup>12</sup>

Two questions were discussed at the Round Table on Hospital Social Service, the first being whether the hospital social service group, as a body, should join the National Conference of Charities and Corrections, the American Hospital Association, or the National Organization; the second was, How workers for this special field can best be prepared. While there was very interesting discussion on both subjects, no conclusions were reached. It was generally felt that the hospital social service worker should have both medical and social training, whenever possible.

#### THE QUESTION OF SOCIAL HYGIENE; AND HEALTH CONDITIONS IN PRISONS

Two papers which are not published in this issue of the *QUARTERLY*, but will appear in the *American Journal of Nursing*, should have some special mention. The first is that of Dr. A. N. Thompson, which deals with venereal diseases and the practical methods now being used to combat them. Dr. Thompson quoted from a letter which has been addressed by the Secretary of War to the Governors of all the states, asking for their coöperation in the repression of various conditions in connection with soldiers' training camps; and also read Sections 12 and 13 of the draft law which gives the Secretary of War practical authority to suppress prostitution in connection with these camps. Dr. Thompson feels that nurses have wide opportunity to assist in the prevention of social diseases, and appeals to them at the present time especially to be very keenly alive to their responsibility in this matter.<sup>13</sup>

The second paper to which reference should be made is that of Mr. Thomas Mott Osborne, which dealt with the subject of "Health Conditions in Prisons." The following quotation from Mr. Osborne's address emphasizes in a way which surely requires no further comment,

<sup>12</sup> A paper by Ruth Emerson on "Medical Social Service as it Relates to Training Schools on Behalf of Student Nurses" is published in this issue of the *QUARTERLY*. A further paper on "Medical Social Service as it Relates to Economical Administration of Hospitals", by Mary Antoinette Cannon, will be published in the *American Journal of Nursing*.

<sup>13</sup> See "A Health Exhibit for Men," by Frank J. Osborne, *Social Hygiene* for January, 1917. Dr. Thompson's address was illustrated by lantern slides which reproduced material used in this exhibit.

the practical value of his plea for more intelligent and humane treatment of prisoners:

It is true that we can none of us escape from the influence of prisons. Look at it in regard to the question of health. I remember at one time talking to a number of prisoners in the Auburn Prison, and one of them turned to me and said, "Mr. Osborne, do people outside realize at all how the diseases we acquire in prison are spread through society? We are shut up here in these cells where a large number of men are certain to get tuberculosis; no care is taken to prevent the spread of other diseases, and then," he said, "then we go out and we associate with those people outside who sent us here amid conditions where we are sure to acquire disease, and we spread those diseases through the community, and that is our revenge."

Miss Gardner, in her Editorial, points out that the all over-shadowing feeling of the Philadelphia Convention was one of patriotism—a sense of collective and individual responsibility to play a worthy part in a national crisis. During the past year, and particularly in the few weeks immediately preceding the Convention, the physical and mental efforts of nurses and board members alike have been strained to meet an unprecedented situation; in the face of the abnormal, and the inevitable excitement and pressure which it produces, it has been their part to carry on steadily, to meet the customary and extraordinary needs of the day with a calmness which should inspire confidence in others less disciplined to meet emergency. The strain of doing this has not been light, but it has been steadily borne; and none of those who were at the Philadelphia Convention can doubt that in the difficulties and perplexities which lie before the nation, the nurses as a body will bear their full share of the country's burden, whether at home or at the actual scene of the war.

#### DUTIES AND OPPORTUNITIES OF DIRECTORS<sup>1</sup>

By GERTRUDE W. PEABODY

When one thinks of a public health nursing association one thinks first, of course, of the nurses who do the practical work for which the association exists. One knows that these women have had the best technical training offered by hospitals and in addition, very probably, a course in public health nursing. The modern conception of the public health nurse lays upon her more varied responsibility than any other visitor to the homes of the poor. Her task is no longer limited to the bedside nursing of a patient. This useful service makes her a

<sup>1</sup> Paper read at Session of National Organization for Public Health Nursing, April 26, 1917.

welcome visitor in the home, but once there her responsibility extends to the whole family, and indeed, to the neighborhood. She seizes the opportunity to make of practical value to the people the knowledge scientists now have of preventive medicine, and she becomes, for the moment, the teacher of hygiene, dietetics and sanitation. Her intimate and friendly relation with the family rewards her with an understanding of social conditions in the home. Furthermore, her observations and deductions must be recorded in statistical form, so that her work may be of service to others in studying some special problem, perhaps of housing, of mortality, or of relief. The nurse's responsibility for any preventable condition ends only when she has found others better equipped than herself to deal with a special condition. One's admiration for the woman who can do all this is very great. She must have a sound body, a well-trained intellect, and a high-minded, self-sacrificing spirit.

There is, however, a less dramatic but equally important part to be played in a public health association by the board of volunteer workers; and it is with this part of the work that I am personally concerned, and about which I may perhaps venture to offer a few suggestions.

In the Boston Nursing Association the members of the board are known as managers, and the head nurse, or executive officer, is the director. A board of managers offers opportunity for work to almost every type of person, and the success of the organization depends upon each member accepting an appointed task and being absolutely responsible for it. There are exceptional instances when unusual persons are welcome members to a board, even if they give little time or personal service to the association. They may be specialists whose advice in some emergency may be invaluable, or they may be persons able to assume large financial responsibility. With such exceptions in mind, however, there may be said to be three kinds of managers. First, there are those who think that by adding their names to the list of managers they are lending influence and respectability to the cause, and are thereby doing their duty to charity. They may feel good but they do not do much good. Secondly, there are those who really mean well, who attend meetings and are superficially interested, but fail to grasp the larger meaning. Their views are often not valuable, but their vote has power. These members must be adjusted to congenial lines of work so that, in spite of themselves, they become sincerely interested and useful members. Thirdly, and fortunately by far the greater number, are those who bring real intelligence to bear upon the subject, and who read and study and keep abreast with the latest developments, and whose opinions have earned the right to be heard.

Managers exist in order to direct; and in these days managers of charity organizations, as of business corporations, are held responsible by the public for the work they direct. They represent the public interests and must see to it that the work is administered economically, and that the returns, in results accomplished, to the investors, are as large as practicable. A dummy manager is no longer acceptable in a charity organization any more than he is in a business corporation. The efficiency of an association may be judged by the work of the managers no less than by the work of the professionals. It is short-sighted to urge higher standards of work and of education for the nurses unless the managers who employ the nurses are also educated to appreciate these standards and to further, in every possible way, the ideas which they represent. The relation of managers to nurses should be a very close one, based on mutual respect and confidence, which results in mutual dependence. The chief danger of an executive officer is that in being a specialist she become opinionated and precipitate, and for that danger the manager with an outside untechnical point of view offers a good balance. Occasionally one hears an executive officer say that her board of managers meddles with her work and retards her. When one hears that one knows that she has not the right kind of managers, but one is also quite sure that she is not the right kind of an executive officer, for an executive officer who fails in educating her board of managers, fails in one of her chief functions. I heard one executive officer lately say that she tried out every new scheme she conceived on her managers. If she could not convince her board of the advisability of her plan she knew the general public would not support her.

The managers should, therefore, equip themselves by giving time for thought and study to the subject, so that they may intelligently fulfill their responsibility of guiding the policies of the association. A year ago the Boston Board of Managers asked Miss Beard to conduct for them a study class in public health nursing, which proved of great value. There are, however, very definite limitations to the usefulness of the lay-worker, and these the wise manager will recognize and not overstep her bounds. Questions of technique and all strictly professional questions must be left to the trained worker. The managers' first and greatest responsibility is the engaging and dismissing of the chief executive. Second in importance is the task of raising the money to carry on the work, and of justifying to the public its expenditure, which rests entirely with them. They should also serve on sub-committees in such a way that all details of the work of the association are intimately understood by representatives of the board of directors. The importance of these committees is especially felt in large associa-

tions where it is absolutely impossible for even the most able and enthusiastic president to keep in touch with all branches of the work, and where she must rely upon the judgment and devotion of her committees. The managers should, in every way, save the association financial expenditure by giving personal service, as far as consistent with obtaining efficient results.

Perhaps I can best illustrate what I have tried to say by giving a few examples of committees from the Boston Nursing Association. Our board consists of twenty-five members. Five religious communions, including the Jewish and Catholic, are represented each by two members. Sub-committees, varying in size from two to eight members of the board, are in very close relationship with all branches of the work, except the actual nursing work which is overseen by supervising nurses. The duties of the managers vary, according to the nature of the committee, in some cases being purely advisory, in some sharing the decisions with the professionals, and in some doing the whole work. For instance: the nurses committee and the supply committee consist of managers and nurses, and as these have to do chiefly with professional questions, the judgment of the trained workers is closely followed, but suggestions and personal effort on the part of the managers results in the one, in materially reducing the expenditure for supplies; and in the other, in establishing a relationship between managers and nurses which develops loyalty to the association. A still more advisory part is taken by the managers on the committee on education, for here the work has to do with the professional training of public health nurses, and an experienced teacher is employed to conduct and develop the courses. But the committee, as well as the pupils, is teachable, if not suggestive, and the head of the department is assured that a small group of the board of managers understands and sympathizes with her aims.

On the other hand, the ways and means committee is made up entirely of managers, and has the full responsibility for the raising of the funds of the association. This committee bears in mind three fundamental principles: (1) That a very small proportion of money raised shall be spent in the raising of it. (2) That the work shall be thoroughly understood by every person contributing to it. These two principles practically prohibit the giving of entertainments by the board. (3) That the raising of money shall be an opportunity for the general advertising and newspaper publicity of the work. The most successful effort of this committee was a house to house canvas, conducted three years ago. The work and aims of the association were described personally at every house. The campaign cost \$150, and \$12,000 was subscribed in one week, a fair proportion of this giving having been renewed each year.

This committee is responsible for the card catalog of subscribers, and the mailing list of possible subscribers, and composes the appeals for money to both groups.

The publicity committee represents the closest coöperation between managers and paid workers, and needs the best thought of both in order to present the work to the public in accurate and interesting form. This committee tried conscientiously to secure newspaper publicity, but were dissatisfied with the results and finally engaged a woman who had experience in this highly specialized work to give half her time to it. But even with this assistance, the managers still have much responsibility. We believe that support for this work will be forthcoming just in so far as people know the value of it, and we want every man, woman and child to know that this nursing service exists for them. To accomplish these two ends is the task of this committee, and it is not an easy one; for the public and the newspapers want their knowledge in story form, and we administrators want them to hear the hard, practical facts.

Still another committee, of which the director is the only professional member, and in which the work is done by managers, is what is known as the Greater Boston Committee. This committee is the outcome of the growth of the nursing work in the districts just outside of the city proper. In these districts the nursing is conducted by the Boston association in exactly the same way as it is in the heart of the city; but in each of these outlying districts an auxiliary nursing committee of residents has been organized. These committees meet with the nurses of their respective districts, visit in the homes of the patients, oversee the supply closets, have a publicity agent, and meet entirely or in part the expenses of the district. The chairman of each of these local committees, and three members of the central board of managers, form the Greater Boston Committee of the association, and much help is derived by the interchange of ideas and plans. Without the aid of these local committees it would have been almost impossible for the board either to have financed or to have developed the work. Through them the different communities have learned to understand the scope of the work, and to have for it a sense of pride and responsibility; and by their representation on a committee of the association the local committees are made a part of the whole organization.

One more example may be cited from the experiences of our board, where the usefulness of a manager assumes a more personal character. There are small groups of two or three directors each, which meet regularly at the headquarters of the nurses in each district. An expert social worker and others interested in community welfare join the group,

and the nurse presents problems that have to do with her patients, and that are not strictly medical. On these subjects the advice of the volunteer may be as valuable as of the professional. Often what is needed to relieve the situation is personal service of some form. A child needs to be taken to and from the hospital, or some interest found for the poor old chronic case, or employment devised for the unskilled wage earner; and the manager to whom human intercourse appeals finds chances for usefulness.

These examples serve to indicate some of the characteristic duties and opportunities of a manager in a local association; but as the interpretation of the cause grows and the interest in it deepens, these duties and opportunities are constantly expanding and one recognizes the advantages that follow from enlarging one's horizon and cooperating with others working over the same problems. The recognition of this fact by a few persons interested in public health, and especially in visiting nursing, has led in Massachusetts to the formation of a state committee of directors of visiting nursing associations. Representatives from the boards of visiting nursing associations in Massachusetts were invited, three years ago to meet and discuss some problems of administration. Many came from associations with but one nurse. The nurses, it was learned, usually belonged to clubs at which they met their professional leaders and gained their inspiration and incentive from them; but the managers were greatly handicapped by their isolation in the work. Their appreciation and enthusiasm for the opportunity has been striking. The state committee organized with an executive committee; county chairmen familiar with nursing work and needs of the counties; a literature committee to recommend to every association the most important publications on the subject; and a legislative committee to bring to the attention of the local associations such bills concerned with public health nursing as seemed to require concerted action. The payment of \$1 enrolls any association and permits any number of its managers to attend the meetings. The organization now has, for the first time, a complete list of visiting nursing associations in Massachusetts, now numbering 117, with the names of the officers of each, the number of nurses employed, the kinds of nursing done, and a record of membership in the state committee and the national organization. This list has already proved of value to the state representatives of the national organization, and makes possible the prompt mobilization of visiting nursing forces in Massachusetts to meet by concerted action a state-wide epidemic or an extensive increase in home nursing as a result of any catastrophe. Fifty-two associations were represented by 120 persons at the meeting in January, and the present membership now

numbers 69 associations. Discussions at the meetings are of administrative problems and of standards of work, and the interchange of ideas and experiences have already proved of value. Managers have returned from these meetings dissatisfied with the work of their associations, and have sought counsel how to improve it. As recognized standards of work are described, managers realize that their associations must conform to these standards or justify their independence of action against overwhelming evidence. The most valuable result, however, has been that the managers united in a common cause, are feeling to a greater extent than before the responsibility and dignity of being promoters of public health, not only for their local association, but for the state as a whole.

Nor is even this the limit of a manager's interest. Just as those within the state have met together for mutual help, so they learn that this same spirit of coöperation may be expanded to reach over the country. Each year the state committee have had the ideals and aims of the national organization described to them, and the part every local association should take in that program. Miss Crandall, a manager and Miss Beard have in turn stirred the managers as they realized what this great movement for the promotion of public health meant, and that the work for which they were personally responsible was, no matter how modest, a factor in the great scheme. Their interest has been broadened and their ambition stimulated by learning what was being done in advanced communities, and they desire to have a part in the national work, if only by insisting that these standards and ideals be maintained, as far, at least, as their interest can make possible.

First, then, is the obligation of the manager to the community that the work be as well done as possible and for the least expenditure; second, is the obligation to neighboring communities that the work be extended and that through coöperation the best methods of work be attained; and third, is the obligation to the country that the work be still further promoted and unified, and that the standard be raised to meet new conditions.

Finally, one may ask, what may such service, conscientiously rendered to the public, mean to the manager herself, besides the happiness which is the natural result of having a small part in an important work? Useful as the volunteer is, the advantage would still, to my mind, be on her side of the scale rather than on that of the cause she promotes. A new interest, as we have seen, has come into her life, and one usually quite removed from her habitual occupations, and it is such interests that add zest to life. New friends have been made from all walks of life, brought together by congenial work, the surest basis

for friendship. Personal knowledge of the unfortunate has developed tolerance and sympathy, and has shown the relationship between dispenser and recipient of charity to be friendly and natural. And lastly, the ability to do things has been created in many lives which had not believed in their own capacity to help. Some persons discover the ability to lead and create, and some to carry out the routine orders; some develop sound judgment, and some are swayed by sentiment; some want human relationships and some want theoretical work—but a visiting nursing association needs and has work for all, and such tasks as writing appeals, raising an endowment fund, making and maintaining a card catalog, issuing an annual report, making speeches, which seemed at first quite impossible, are able to be accomplished by an intense faith in the cause they advocate. The manager who slights her work gives little help to others and gets little help for herself; but she who does her work to the best of her ability finds the ability grow with the responsibility and happiness follow the task.

#### THE PUBLIC HEALTH NURSE AND THE AFTER CARE OF INFANTILE PARALYSIS<sup>1</sup>

By EDITH SWAINE, AGNES M. SJOLUND AND CLARA JOHNSON

About one year ago a 13 year old girl was brought to the hospital on a stretcher. Both hips and knees were in permanent flexions at an angle of 45 degrees—one foot was badly deformed. There was a severe scoliosis due to the child having lain for so long a time on one side with head and shoulders elevated. Ten years ago the child had had infantile paralysis. The muscles of both legs and one arm had been affected. After one year's treatment, including several operations for correcting the deformities, the child can now sit erect. She can lie on either side or on the back with legs fully extended. There is some increase of muscle power. With such marked improvements in only one year's time, after having been helpless for so long, there is reason to believe that with continued treatment and with the aid of braces and crutches the child will soon be able to walk. Three months ago a 12 year old boy came into the hospital. Since an attack of infantile paralysis seven years ago his manner of locomotion has been walking backwards on all fours. In his case, fortunately, there were no deformities to be corrected. He was fitted with corsets, braces and crutches and is now learning to walk like a human for the first time in seven years. Only recently have we realized that it is not necessary that infantile paraly-

<sup>1</sup> Paper read before session of National Organization for Public Health Nursing, Philadelphia, April 26, 1917.

sis victims endure such miserable existences and it becomes the opportunity of the public health nurse to see to it that none of the thousands who were stricken this past year and who may be stricken in following years shall endure such a helpless, hopeless life.

This means an educational campaign. People must know that, with proper care, there will be a complete return of muscle power in many cases and that in all cases there will be some return of muscle power and in all cases deformity can be prevented.

The degree of return of muscle power is dependent to a very great extent upon the treatment during the acute stages. Immediately following the paralysis the parents are so zealous to do something to try to produce motion. They must be taught that quiet reduces to a minimum the amount of irritation in the cord, thereby favoring the early absorption of the cause of pressure. They must be taught that any kind of manipulation during the acute stage or so long as any tenderness exists only aggravates the condition. A 5 year old boy became ill in October; although not marked, from the outset there had been some sensitiveness. Massage had been given for four months, at the end of which it had to be discontinued, because of the pain produced. Since receiving no treatment other than daily hot salt baths, the child's condition has greatly improved. Because of an increased tenderness following an examination it has been decided that the child shall be kept absolutely quiet until the tenderness has entirely disappeared. Another child who had been receiving massage for seven months was brought into the hospital, having what seemed to be a double hip flexion deformity. Upon examination, extreme sensitiveness was found. The child was placed in a position where the legs were supported just enough to relieve all tension at the hip and knee joints. The support was reduced gradually without other treatment. In three weeks' time the legs could be fully extended without causing the patient any discomfort.

There is much diversity of opinion as to the methods used in the after care of infantile paralysis, but the principle upon which these various methods are based is practically the same. To prevent deformities and to secure the return of the maximum amount of muscle power fatigue must be avoided. After the acute stage is over and all tenderness has gone, each day the child learns he can do some new stunt. Usually he is encouraged to make the effort hour after hour, day after day, for the parents know that exercise develops muscle power but they have not yet learned the harmful effects of fatigue upon a weakened muscle. Fatigue oftentimes allows the muscle to be kept on the stretch, and an over-stretched muscle seldom regains its power of contractibility. A very common deformity, valgus, where the child walks

on the inner border of the foot, is due to the over-stretching of the muscles that invert the foot. Usually, in the beginning, these muscles are only weakened and if the child is kept off his feet or the foot forcibly held in its normal position while limited exercises are being given for the development of the muscles, there is no reason for his having the deformity. If, however, walking is persisted in, the weight of the body keeps these muscles on the stretch so constantly they lose their tone and the deformity becomes permanent. Fatigue in all cases means the lessening of the chances of recovery and in many cases means the permanent loss of power in what, in the beginning, was only a weakened muscle. The parents having the knowledge of the whys and wherefores of the treatment that a busy physician usually has not the time to give, can then see the necessity of restricting their child's activities to exercises that can be graded to individual muscle groups, and that can be stopped before the fatigue stage has been reached.

That deformities may be prevented, frequent medical supervision is necessary for at least two years and possibly for four and even six years. To many, this is a financial impossibility and for these clinic care must be provided. Then, too, these mothers meeting at the clinic two or three times a week, as the case may be, receive from each other encouragement to continue the treatment that the stay-at-home mother does not get. After six months of medical supervision, most parents feel there should be a greater return of muscle power. They do not appreciate how very much the child is being benefited, in that all parts of the body are growing straight. They do not understand why it should require a longer time for a complete recovery. And their failure to understand that time is an important factor in this recovery drives some of them to almost desperate measures. One mother is having her child treated by a man who is not a physician,—who has guaranteed to effect a cure in six weeks. She reasons that even though these treatments do cause the child much pain, they cannot harm her and may cure her, so she must be given the chance. Another mother is trying one kind of treatment one month, if there is no improvement she will try another kind the next month and then expects to try a third kind. The pity of it all is that both these children have been under the care of competent men. There is no indication of any deformity and there has been much return of muscle power. These mothers are not unintelligent, but they need more than instruction, they need more than supervision, they need coaching and encouragement to continue the same practicable treatment during the years necessary to secure the greatest degree of improvement. All of these patients must be visited frequently, even though it be unnecessary for them to be seen by a physician more

often than every month or two. One mother, who is trying most faithfully to follow her physician's instructions, was found to be overstretching the muscles. A child after having been advised a brace was told to report to the physician in six weeks' time. The nurse, going into the home two weeks later, observed that the brace was not accomplishing what was expected of it. After consulting with the physician, it was learned that the brace-maker had not followed instructions and the brace, as made, was increasing the condition it was intended to correct.

The mother who, on crutches, is making an attempt to care for herself and two children cannot be expected to attend clinic treatment two or three times a week, nor can children who, nerves shattered from what they have already gone through, are terrified at the sight of strangers. For these and others home-treatment must be provided. The general instructions for all these cases are very similar—restrict activity, maintain correct posture, massage or give exercises as prescribed. They sound very simple, but home conditions oftentimes make it very difficult for them to be followed.

Susie became ill last September, she could not sit alone, was unable to move arms or legs. She was living in a miserable basement, sitting all day hunched up in a baby carriage several sizes too small. This position was producing a scoliosis and contractures, but there was no other place for her except the bed back in a dark corner, and no 6 year old with an active mind would be content there. To restrict the activities of a 5 year old youngster who is normal in every respect, with the exception of a few muscles in the right thigh, is no small task. However, the mother was succeeding remarkably well when she became ill. During the two weeks that the boy ran free, there was such a marked change for the worse in his condition that the physician thought it advisable to put the leg in a cast until the mother could take him in hand again. Then there is the little girl for whom exercises were ordered. To secure the best results much concentration of thought on her part is necessary, but she is undisciplined and the mother discourages rather than encourages her in making the effort. Notwithstanding this, through the persistence and tact of the nurse, the child is making much progress toward recovery.

The one who is to instruct these parents must herself know the disease, the changes in the tissues it produces. She must know and understand the principles upon which the treatment is based, that she may give the home-care she must know the mechanics of the treatment. She must be able to recognize the slightest tendency toward a deformity. She must understand the purpose for which apparatus is advised and

to know whether it is fulfilling that purpose. Then, too, she must be one who can be a sort of moral support to the parents during the years required for treatment and she must be one who can adjust the treatment to house-conditions. The masseur does not qualify for the task, the general public health nurse does not qualify, the public health nurse who has had special training in the after care of infantile paralysis does qualify for the task, and if we are to make the most of our opportunity of preventing children from becoming hopelessly crippled, there must be more public health nurses who will secure for themselves this special training.

### THE NURSE AND INFECTIOUS DISEASES<sup>1</sup>

By GEORGE W. GOLER

The nurse's training, or so little of it as in part pertains to the care of infectious diseases, has led her to believe—what? Just about the following: If newly bathed and freshly dressed she crosses the threshold of the sick-room, where she finds the center of infection—the patient—she adopts a plan of procedure about like this: Rugs, window curtains, and all the so-called deadly carriers (?) of infection are removed. The toilet of the patient (and it is to be hoped this includes cleaning the teeth and mouth with brush, swab and dental floss), and the bed are made, the furniture and belongings are wiped off with some favorite smelly disinfectant, a wet sheet is pinned in front of the door, or the door kept closed; all of the dishes, clothing and toilet utensils of the patient are cared for, and the nurse walks in and out of the room without cleaning or disinfecting her shoes. Why she should clean or disinfect her shoes I do not know, except that she ought to be as unreasoning and antiquated about such a procedure as she is in the unnecessary and superstitious use of disinfectants in which she has indulged in the attempted care of the patient and his surroundings.

While exercising all of this so-called care, she ever and anon puts her fingers in her mouth and puts her hands to her face, though she does not forget to wash her thermometer nor finally to wash her hands in some favorite Buncum disinfecting solution, or to scald the dishes or wipe off the door handles; and never, no never, does she fail to keep that sheet wet with the disinfectant or to keep the door of the room closed, because of that antiquated fear that the large blue bacilli of

<sup>1</sup> Paper read at Joint Session on *Some Modern Demands on the Graduate Nurse*, Philadelphia, April 27, 1917. Other papers read at this session, to be published in *American Journal of Nursing*: "Mental Hygiene," Jessie Taft, Ph.D.; "The Prevention of Diseases of Infants and Children," Ellen C. Babbitt.

diphtheria or the scales of scarlet fever will fly out through the doorway and strike the first passer with the deadly disease.

So she proceeds throughout the illness, attempting to disinfect everything, even following the recommendations contained in the quack literature of the manufacturers of disinfectants, whose sole business it is to sell their wares, to get the medical profession and the nurses to act as their unpaid advertising agents, and to make money thereby. Have you ever seen a nurse dressed in the clean white dress, the picture of neatness and propriety, with a little cap perched on the middle of her head, so as to protect that particular part of the head from flying germs, and, with a bottle of Flats Florides, descending the cellar steps, lifting the cover to the hot-water pan so as, as she thinks, to disinfect the air of the house by putting a little of the 50-cent mixture into the hot-water pan? How the manufacturers of this polite fraud must laugh at that Twentieth Century superstition in medicine and nursing, which allows such practices to persist.

And then, when the siege is over, the cleaning is bulwarked by disinfection with some of Faker's Formaldehyde. And then, again, when she has bathed and washed her hair, not forgetting the disinfectant, she breathes easier, because she feels that her duty has been well and nobly done, even though she may have forgotten to disinfect her shoes. Of course, it may have been really an error to wear shoes. A thoroughly conscientious and painstaking nurse of the disinfecting order, if she is really consistent, ought not to have worn shoes. She might, of course, discard her shoes every time she stepped without the portals of the sick chamber; but what she really ought to have done, is to renounce shoes and stockings, have a pan of favorite disinfecting solution near by, and disinfect her feet every time she leaves the sick room.

When a nurse leaves a hospital what ideas does she carry with her concerning the management of infectious disease? Until very recently, at least, has not her training been such as to teach her that infectious diseases are air borne? Hasn't she a hazy kind of a notion that disease comes out of the air and that to protect the patient, herself, and those about her from the disease, it is only necessary to disinfect the air and the belongings of the patient? Is not this to her the whole marrow of infectious disease nursing as she understands it? Hasn't the nurse seen disinfecting go on in the hospital wards and rooms? Hasn't she seen them disinfect the ambulance with some horrible, smelly stuff? Hasn't that sort of thing been her old, old teaching, a teaching musty with age, hoary with tradition, odoriferous of the time of Defoe and the Plague? She has seen her teachers, physicians and nurses don a gown, decorate the head with a cap; and if she is watchful, she may, too,

have seen the hands of the same teacher carried to his face, the fingers carried into the mouth, and she sometimes may have seen that same teacher leave the hospital or the patient without washing his hands.

With all this attempted care of the air, the clothing and things about the patient, the nurse wears a gown and cap and, neglecting to keep the hands away from the face, the fingers out of the mouth, how many times has she or have a group of nurses witnessed cases of secondary infection? And when she has seen them have they not been traceable to "carriers?" With the exercise of ordinary care in cleanliness, it is even difficult to infect susceptibles.

Does the nurse know that of several thousand experiments to determine whether the germs of diphtheria can be found in the sick-room where diphtheria exists, only a very small percentage of cultures have shown the presence of organisms in the dust of the floor, on the walls or even on the bedclothes about the patient's bed? It is the hands, the fingers carrying infection from the mouth, anus or urethra that are largely responsible for the carriage of infectious disease. Even the coughing patient is not able to scatter infection beyond arm's length, for the striking distance of disease is very short.

The nurse has not been taught, or if she has been so taught she does not stop to think, that the parasite bacteria which cause infectious diseases do not always readily grow outside the body on artificial media, and if they do not thus easily grow how much more difficult is it for them to grow or even be kept alive on clothing, hangings, etc., or the outside of the body? Things outside the body are, therefore, little dangerous and require cleanliness not disinfection. They are no more dangerous to the living, even if they be non-immunes, unless they are carried to the mouth by fingers, in the food, or breathed in from mouth spray coughed up by the patient. For the same reason those dead from infectious diseases are not dangerous unless the body is handled and the organisms carried to the mouth by the hands.

Has the nurse in her training or in her later reading or experience fixed and clear ideas of the general principles of infection and protection in the commoner infectious diseases? For instance, does she know that whooping cough is immediately dangerous to the life of children under one year of age, and that nearly all children can be protected against it, at least for a year or two, by vaccination with pertussis vaccine? Does she know that in whooping cough the dangers of infection are greatest in the beginning of the disease, and though they may be present even after the whoop ceases, it is the first two or three weeks of the disease when the danger of infection is greatest? But the thing to do for whooping cough is to keep the child much in the open air.

The open-air treatment of whooping cough is the best treatment known. Washing the child's hands and face and keeping it free from saliva and vomitus, is the best way to prevent the extension of the disease. Does she know that measles is most dangerous a few days before and three or four days after the appearance of the rash, and that afterward, unless there is a muco purulent discharge from the throat or ears, measles is rarely infectious after the first few days? Does she know that in scarlet fever the rash is but an expression of the disease? The infectious cause of the disease is chiefly in the throat. The scales of scarlet fever have nothing whatever to do with the dissemination of the disease; but, as in measles, throat and ear discharges are responsible for spreading it. Does she know that in diphtheria, where the most susceptible age is between two and five, nearly all new-born babies and most children and adults fifteen years or over, are immune to diphtheria, because they have circulating in their blood sufficient antitoxin of their own making to protect them against diphtheria?

The reason people, chiefly children, get diphtheria, is because they have not enough diphtheria antitoxin of their own making in their own bodies to protect them against the disease. To such persons we give diphtheria antitoxin, because they have not enough of their own antitoxin. And here let it be understood, that diphtheria antitoxin has no effect upon the germs of the disease. Diphtheria antitoxin is not an anti-germicide; it is anti-toxin. It has no effect on the membrane in the throat. It does combine with the toxin or poison excreted by the diphtheria germs, and when given early and in one large and sufficient dose, it prevents the poisonous toxins of the disease from exercising their deadly influence on the body, chiefly on the heart. Given late and in small doses, it is often of little or no value, because the diphtheria toxins have combined with the tissues. Diphtheria antitoxin can only combine with the free toxin. After the toxin has combined with or become locked in the tissues, diphtheria antitoxin cannot affect it.

The susceptibility of all persons to diphtheria may be tested by what is known as the Schick test. They may be made temporarily immune against the disease by the administration of diphtheria antitoxin, and permanently immune by the injection of toxin-antitoxin mixture. Every nurse who cares for diphtheria owes it to herself, at least, to see that she is tested against diphtheria, and if she is susceptible that she is made immune against the disease. So, too, in typhoid fever, where the nasty practice of putting the fingers in the mouth has been responsible for making a short circuit between the bowel of the patient and the mouth of the nurse, nurses have been attacked by typhoid fever,

both because of the dirty habit of putting the fingers in the mouth and also because the nurse has stupidly or foolishly or both neglected to be vaccinated against typhoid. Today every patient with typhoid is an example of one who doesn't know enough to avail himself or herself of the modern practice of protective vaccination against typhoid fever. No patient who today gets typhoid fever should receive compensation or sympathy. To neglect anti-typhoid vaccination today is just as much negligence as going to sea without a compass.

Does the nurse know that pneumonia is an infectious disease? It has been classified into four types by Cole and Dochez of the Rockefeller Institute. For Type 1, causing about one-third of all cases of pneumonia and about one-fourth of all deaths, a new serum has been devised for treatment; but the way to prevent pneumonia is to take care of the general health, to employ a dentist who believes not so much in mechanical dentistry as he does in preserving the teeth; to pay strict attention to the toilet of the mouth and throat and to wash the hands and keep the fingers out of the mouth.

Does she know that tuberculosis is a social and economic disease rather than purely a medical disease? Large numbers of cases are caused by organisms taken into the body during childhood and their release into the lymph streams later in life as a result of stress or concurrent disease. The same care in cleanliness will serve to prevent tuberculosis, just as it will serve to prevent the other common, infectious diseases, gonorrhoea and syphilis included; for these infections are carried not by germs on doorknobs, blankets or wallpaper, but rather by that reversion to an ancestral characteristic of our ring-tailed ancestors, the nasty habit of putting the fingers into the mouth. For the germs of disease, though numerous, are little things from  $\frac{1}{4}$  to a  $\frac{1}{20,000}$  of an inch

in length, and from the patient to the observer is a long way for such a little thing to spring. You know the story of Mrs. Casey, who lived in a family proud of their ancestry. Asked what line in Ireland she sprang from, she replied; "In the part of Ireland I come from we spring from no line, we spring at them." Germs do not spring, they are carried in food and in other ways, on the fingers. I could not help but think of Mrs. Casey when, one recent day, I was not permitted, for just a moment, to enter the operating room of a hospital without a gown, because, as the nurse in charge said—"They had so many cases of infection until they got all doctors coming into the room to put on gowns."

The training of the nurse in infectious disease work has been generally so bad that when nurses come to work for us in the Health Bureau,

the first thing we do is to try to get them to cast off all the old notions of infectious disease they have gathered from their former teaching. We try to teach our nurses that if they are successfully to handle infectious diseases they are to rely upon vaccination or immunization or both as a protection for themselves, and to protect their patients against others. They are to learn to wash their hands in soap and water without any kind of disinfectant. And they have further to learn to wash their hands and keep their fingers out of their mouths. There is no other way in which the nurse may rid herself of that stupid fear of infectious diseases, which is conceived in ignorance, born in superstition and raised in wilful disregard of known scientific facts. The same general rules apply to syphilis and gonorrhoea.

It is so easy to protect people against most infectious diseases, and if it is thus easy and simple, why should not the nurse with perfect safety go from a case of diphtheria to one of erysipelas or from a case of scarlet fever to the lying-in room. Is there any reason why there should be special maternity nurses, post-natal and pre-natal nurses, whooping cough, measles and scarlet fever nurses, diphtheria, typhoid and tuberculosis nurses; nurses for pneumonia and nurses for smallpox? Why should not the city be districted in which a public health or visiting nurse is to work; and, why, with these facts before us should not the nurse do the work in her district, whether it be maternity nursing, infectious disease nursing or ordinary bedside nursing of the child or the invalid?

If the nurse were only willing to follow the ordinary rules of cleanliness, much of the overlapping complained of with some justice by our critics, would be largely overcome. New York City says we are being "nursed to death;" and Pennsylvania says we are being "inspected to death"—and there is some justice in these strictures upon our conduct. I recall the story of a merchant who, with a crowded store, was accosted by a friend with the remark—"My! business must be good!" "Business?" said he in reply, "this ain't business, this is the mercantile inspector, the gas inspector, the plumbing inspector, the child labor nurse, the infectious disease nurse, the tuberculosis visitor, etc., etc."

There are today three general kinds of nurses: Health nurses who do no nursing but who prevent sickness; bedside nurses in the home and hospital, who do nursing; and industrial nurses, who prevent sickness and accident. We are here interested in the health nurse and the bedside nurse, because they have to do with the visitation and care of infectious diseases. I have already outlined to you a simple plan for the care of infectious diseases. Let me say to you that the basis of this plan is built upon the care and observation of more than 2,000

cases in an infectious disease hospital, where for five years the same nurses have cared for cases of whooping cough, measles, scarlet fever, diphtheria, gonorrhoea, syphilis, meningitis, poliomyelitis; and these same nurses have frequently had under their care in the same wards diphtheria, whooping cough, erysipelas and measles or scarlet fever, and the only precautions against cross infection have been the wearing of a separate gown for each disease, washing the hands in soap and water and drying them on a paper towel. No disinfectant of any kind has been used, either on the hands, on the clothes or about the patient or the wards, and the percentage of cross infections during this period has been less than 2 per cent.

All this work teaches that, if she is to succeed, the nurse of today must introduce into her work present-day intelligence and efficiency, not antiquated conjecture and superstition.

#### HOW CAN THE SMALL HOSPITAL TRAIN PUPILS TOWARD PUBLIC HEALTH NURSING?<sup>1</sup>

By MARY S. GARDNER

The beginning of the twentieth century (1901) found about one hundred and thirty nurses engaged in public health nursing in the United States. The year 1917 finds over six thousand. This phenomenal growth of public health nursing work lays a heavy responsibility not only on those actually engaged in the field of public health nursing, but also on those responsible for nursing education.

In the earlier days of the public health nursing movement, this responsibility of the training schools was easily met. "Give us," cried the visiting nurse associations, "a nurse skilled in the care of the sick, accustomed to dealing with the medical profession, and with a right personality, and we will ask nothing more from you." The cry now is a very different one. "Give us" say the multitudinous agencies engaged in public health nursing, "a nurse who has added to her knowledge of the care of the sick and her understanding of professional etiquette, a knowledge of how to teach the well to avoid illness, how to deal with boards of managers, how to speak in public. One who understands the social causes of sickness, the elements of urban and rural sanitation, and the many reactions of city life upon health problems. A woman who can march shoulder to shoulder with other

<sup>1</sup> Paper read at Joint Session on *The Problem of the Small Hospital*, Philadelphia, April 27, 1917. Other papers read at this session, to be published in the *American Journal of Nursing*: "Administrative Problem," Marie Brown; "Educational Problem," Claribel Wheeler.

reformers and social workers in the general effort to secure right conditions. That she must be a woman of professional ability goes without saying, but she must also be a woman of initiative and who so well understands the science of coöperation that she will make no false steps in the delicate adjustment of her work to that of others."

The response of the training schools to the earlier plea for a nurse skilled in the care of the sick was a ready one. "We have such a nurse as you require," they said; "for three years we have carefully prepared her to care for the sick, to work with doctors, and to so develop her personal character as to meet your need." To the later plea, the response is as different as the demand. "We have no such nurse" is the reply. "We do not teach diseases considered as community problems, or the science of sanitation, either rural or urban. Our nurses know nothing of boards of managers, public speaking or coöperation with other agencies. How should they? And as for leadership and initiative, should we not have chaos in our hospitals if we tried too vigorously to instill these attributes into our young undergraduate nurses?"

The least thoughtful must recognize the great difficulties of the training school superintendent, obliged to meet a constantly increasing educational demand created by changing conditions, and obliged at the same time to provide for the care of the sick in the hospital by her student body, backed often by a directorate not primarily interested in educational matters, and not infrequently with little knowledge of them. History will do full justice to the hundreds of women who have so nobly met this situation, and who in the face of almost impossible difficulties, have steadily raised the standard of nursing education to where it stands today. Far be it from those who have a simpler task to wantonly add one new and unnecessary burden.

The question as to whether the training school should be responsible for the specialized education of the public health nurse is answered in three ways. Many feel that the training school fulfils its educational obligation by fitting the nurse to care for the sick, as the college gives a general education, and that specialized training such as public health nursing ought rightly to be obtained by the student after graduation, as the graduate of a college, no matter how well-equipped, expects to enter a law or medical school if he is to be a lawyer or a doctor. Those advocating another point of view feel that a woman who has paid for her training as the pupil nurse does by so many hours of work, ought not to be expected to enter upon another period of training on graduation, if she wishes to enter the field of public health nursing. A third group takes a middle course and feels that, while it is impossible for the hospitals to make adequate provision for public health training,

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the pupils should receive before graduation a certain insight, both theoretical and practical into this branch of nursing.

It is unnecessary in this discussion to enter into the pros and cons of these different points of view. Granted that it is thought desirable to give some measure of training in public health nursing to undergraduate nurses, how shall this be done, and how particularly shall it be done in smaller hospitals?

All nursing education divides itself into two parts, the theoretical and the practical. Let us first consider the question of theoretical instruction.

Last year the Committee on Public Health Nursing Education of the National Organization for Public Health Nursing made certain valuable suggestions with a view to giving to pupil nurses, not an adequate training in public health nursing, but some insight into subjects connected with community health and the social causes of illness. It was proposed that early in the nurse's first year a slight turn be given to her mental attitude by a course of five lectures on sickness as a social problem, and also by a few days spent in the social service department of her hospital, or with a local visiting nurse association, in order that the home conditions of hospital patients might be visualized.

In the second year, it was proposed that the usual lectures given on the physical aspects of the various diseases be supplemented by others dealing with tuberculosis, venereal diseases, mental diseases, etc., in their relation not to the individual but to the community.

In the third year, the committee recommended a series of, perhaps, fifteen lectures, five on the special branches of public health nursing, and ten on such modern problems as labor conditions, immigration, housing, prostitution, etc.

For the hospital, large or small, situated in a city or in a town where well-developed social agencies exist, it will not be so very difficult to obtain lectures. Better courses by better people can, however, be asked for if the group to be addressed is a large one. It may, therefore, be suggested that the various schools affiliate for such a course, the classes meeting in a common lecture room for the lectures. Such an experiment has already been tried in this very city (Philadelphia) during the past year, no less than fifty-five training schools uniting in the affiliation.

For the training school situated in an isolated locality no such arrangement may be possible. If good lecturers cannot be obtained, the superintendent of nurses will have to add one more duty to her already well-filled routine. Unless, however, she has had some experience in public health nursing, she will do well to provide herself with the care-

fully written lectures prepared by the League for Nursing Education on these subjects. These "canned courses," as they have been called, are of course not nearly as pleasant to the taste as the fresher fruit of personal experience, but they make an excellent substitute where lecturers are hard to secure, and can be supplemented when possible by single lectures or courses from the nurse lecturers and teachers who are beginning to offer courses and classes on specialized subjects on a business basis.

So much for the theoretical part of public health instruction.

The practical training is at once simpler and more complex to arrange for. This may be given through affiliation with a local visiting nurse association, or it may be given directly by the training school itself. If given by the training school, special supervision by a trained public health nurse must be provided. If given through affiliation, the expense to the hospital may be reckoned as the exact amount of the maintenance in the training school of a nurse who is wholly unremunerative to the hospital. If more than one nurse is sent out at a time, the amount will naturally be correspondingly increased. If the training school itself undertakes the training the cost of supervision must be added, also the cost of transportation, outdoor uniforms, bag, supplies and record cards. The advantage of the affiliation method is much more far-reaching than in the mere matter of expense. Better and more standardized methods are usually taught by an organization whose sole object is the knowledge and use of such methods, and the public is better served through unification of the work. If, therefore, a local visiting nurse association exists, the first step should be an effort toward affiliation with it.

Just here the training school should exercise a power not always made use of. The training school stands primarily as an educational body, which the public health nursing association does not. Let the training school therefore be very insistent in its demands for a proper supervision for its pupils. None know better than experienced public health nurses how often the use of pupil nurses has been abused by visiting nurse associations, not wantonly, but through ignorance. The board of managers of a visiting nurse association are rarely versed in matters of education, and too often driven by the rapid growth of their work to the necessity of securing more nurses, they have thoughtlessly allowed the exploitation of the pupil nurse for the work to be obtained from her, giving in return no *quid pro quo* in the way of training. Most visiting nurse superintendents will gladly welcome the aid of the training school superintendent in making plain to her board the responsibility involved in the taking of pupils.

The size of the visiting nurse association need make no difference provided pupil nurses are not taken in undue proportion to those who are to teach them. The training school should, however, inform itself in regard to the ability as well as the willingness of the staff nurse or nurses to teach and should make very specific demands in this respect. Pupils should be returned to their hospitals for all classes and lectures, as it is rarely possible to arrange the training school curriculum so that this is not necessary. No pupil should be sent out early in her training. The third year is generally conceded to be the best, because the pupil should be thoroughly grounded in nursing technique before she is expected to make such modifications as are often necessary in the homes of the poor. Written reports should be sent to the superintendent of the training school at the termination of the pupil's period of training.

Twelve years of experience of affiliation between a visiting nurse association and hospital training schools, which happen to have been both large and small, leads the writer to the conclusion that practical training in public health nursing is alike desirable for the hospital, the individual training school, the pupil, the visiting nurse association, the local community, and the general cause of public health nursing. The hospital gains from the better understanding of its function, spread broadcast through the community, and also by the more sympathetic care of its patients induced by a clearer insight into the home conditions of the poor. The training school gains by the broadening of its curriculum, which helps it to graduate better educated women. The pupil gains in a knowledge of social and physical conditions which the hospital cannot teach her, and her interest is awakened in one of the important branches of nursing, which later she may wish to take up. The affiliated visiting nurse association gains by the fresh and eager interest brought to it by the advent of each new pupil. It gains in that its staff is stimulated by the necessity of teaching. It gains by the close bond with the hospital and training school. It gains in the ease with which its application list is kept up, and its knowledge of the work and character of applicants. It also gains in the practical detail of the work accomplished by the pupil. The community gains from all these facts in that it is on the whole better served. The cause of public health nursing gains principally from the awakened interest of the student nurse, early in her career, and also indirectly from each of the foregoing arguments in favor of undergraduate training or partial training.

To sum up, the small hospital as well as the large can give to its pupils a certain amount of theoretical instruction on public health subjects by means of lectures arranged to supplement other theoretical

instruction. These courses may be given by affiliation with other schools or, if the hospital is situated in an isolated locality, by means of lectures prepared for such use. Practical training should only be undertaken under favorable conditions, where exploitation of the pupil for the work to be obtained from her is duly guarded against. If the training school itself gives practical training, it should be done under a trained public health nurse, giving her entire time to such instructive work. It is preferably given through affiliation with a local visiting nurse association. If by the latter means, the training school should demand for its pupils instruction in modern and standardized methods of work, continuous systematic educative supervision, fair hours of work, prompt and regular return to the hospital for all lectures and classes, and reports of progress at the close of the training period. Failing such arrangements, practical training should not be undertaken.

#### THE LIVES AND HEALTH OF MOTHERS AND CHILDREN: HOW CAN WE SAVE THEM?<sup>1</sup>

By EDWARD P. DAVIS

In this day of advanced medical science, is there a crying need for great improvement in the care of parturient women and the care of mothers and infants?

The mortality statistics tell us that in the United States from 1901 to 1905 the annual average of deaths from the accidents of pregnancy was 549; from puerperal hemorrhage, 337; from other accidents of labor, 295; from puerperal septicaemia, 2057; puerperal convulsions, 911; puerperal phlegmasia albadolens, 4; from other puerperal accidents, 488; puerperal disease of the breast 1; a total of 4642 deaths occurring among mothers annually from diseases and accidents connected with pregnancy and labor. This does not include stillbirths or conditions which pertain to stillbirths only. When we compare this number of deaths with those occurring in women from cancer of the breast and cancer of the uterus, we find that the number of deaths from pregnancy and labor very nearly equals that of cancer of the breast and cancer of the uterus. Among infants from malformations and diseases of early infancy an annual average death rate of 26,511 is cited. A recent report from the Children's Bureau of the United States Department of

<sup>1</sup> Paper read before Joint Session on *Maternity Nursing*, Philadelphia, April 28, 1917. Other papers read at this session, to appear in *American Journal of Nursing*: "County Units for Maternity Service," Dr. Grace Meigs; "Opportunities of the Prenatal Nurse in Connection with Venereal Diseases and Prevention of Blindness," Miss Maude S. Smart.

Labor by Dr. Grace L. Meigs states that in 1913 at least 15,000 women died in this country from diseases caused by childbirth, of whom 7000 died from puerperal septic infection and the remaining 8000 from diseases now known to be largely preventable or curable. Taking the statistics for 100,000 population, childbirth was a little less fatal than typhoid fever and if the statistics of typhoid fever were limited to women only, childbirth would be four times as fatal. Tuberculosis only shows a higher death rate among women between the ages of fifteen to forty-four years. Furthermore, while in the last thirteen years there has been a marked diminution in the mortality of typhoid fever, diphtheria and tuberculosis, no such decrease is shown in the mortality attending childbirth.

When the conditions pertaining in this country are compared with those in foreign countries, we occupy an unenviable position. Of fifteen important foreign nations, only two show a higher death rate attending childbirth than does the United States. Sweden, Norway and Italy have remarkably low death rates, while there has been a marked diminution in the last thirteen years in the death rates in England and Wales, Ireland, Japan, New Zealand and Switzerland.

One can possibly obtain a better idea of the conditions prevailing throughout our country by reference to reports upon rural obstetrics from three townships selected; one in a northern central state, one in the Middle West and one in the South. In the first, 50 women were interviewed, of whom about 48 had a physician at their last confinement, one was attended by a neighbor and one by a midwife. Only 7 of the 50 mothers had any attention by a physician before the birth of the child and of these 7 cases, one visit was paid in each case. Only 3 of the 50 had an examination made of the urine and in these but one examination. The pelvis was measured in but one case. There were a number of diseased conditions occurring during pregnancy which received no attention. One woman described nephritis, another had severe toxemia with headache and edema of the whole body and this woman had had nephritis in a former pregnancy. Neither of them had care before childbirth. In 13 out of the 50, the physician made no visit after the confinement; in 24 but one visit was made. Four of the infants were delivered by forceps and one of these mothers died from hemorrhage a day later. The child was stillborn. No physician was called in consultation. Five of these women had more or less severe hemorrhage after labor; 3 had adherent placentae; 1 had fever on the third day; 1 an infected breast; another thrombosis of a vein in the thigh from which she suffered nine weeks. None of these women had a trained nurse at confinement; 7 had practical nurses; 25 a relative

or a friend; 13 a neighbor or a friend who came in from outside. These conditions pertained in a prosperous state and in a township no part of which is more than six miles from a doctor and where telephones are commonly used. The nearest hospital was about 20 miles distant.

In the township in the Middle West, one-half of it was comparatively near a progressive small city from which a doctor could easily be obtained, but the other half was in a wilder part of the country, eight to twenty miles from a hospital. In this township, of 50 mothers, 28 had a physician, as they lived comparatively near the town. Only 9 had attention during pregnancy and in 5 but one examination of the urine was made, while but one patient had more than one examination. Out of 28, 18 had no visit from a physician after labor, although 7 had been delivered with forceps.

In the Southern township there was difficulty in getting a doctor and in some cases the doctor did not arrive until the child had been stillborn. In one case a woman who had had children was taken in labor and birth did not occur spontaneously, but the physician summoned could not arrive until the following morning. Labor had been delayed by an abnormal position of the child which was finally delivered dead. The mother was seriously ill for more than a month. One pregnant patient while working in the field had a sudden and severe hemorrhage. In a heavy storm the husband drove with the patient nine miles to the nearest town for medical help. Of 50 mothers, 26 were white and 24 colored and of the 50 but 10 white women were attended by physicians, the remainder had colored midwives. None of these women had trained nursing care and only one had a practical nurse.

What could be done to improve these conditions? Prof. Irving Fisher in his report on National Vitality before the National Conservation Commission states that out of 100 cases of premature birth, 40 could be prevented; of congenital debility, 40 could be prevented; of venereal infection 70. Diarrhea and enteritis, the most important cause of infant mortality, could be prevented in 60 out of 100 cases. Convulsions, which are such a bugbear to mothers, could be prevented in 60 per cent of cases. Of all diseases of infancy, 47 per cent could have been prevented. From 100,000 to 200,000 lives might have been saved each year.

We will not weary you with statistics, but they indicate that there is ample evidence of great need in improving the conditions of childbirth in this country.

The present is a peculiarly favorable time to secure this change. The wastage of human life in Europe has been so great and the demands

for active workers in this country so exceeds the supply that human life has an economic value which it has never before possessed. The legal value of a human life is its wage earning capacity, and hence a child too young to work has but a sentimental value, and one is not surprised at the irony of a court who awarded damages of 39 cents to the parents of a little child killed by an accident, on the ground that some sentimental compensation should be made, but as the child was too little to work, its life had no economic value. Human life has heretofore been the cheapest of commodities. Those who remember the early conditions of railway travel know that for a long time men were obliged to go between railway cars to couple and uncouple them and that a large number of deaths and accidents resulted. At that time there were in existence inventions which would have overcome this danger, but it was cheaper to pay for life and limb at current rates than to install these appliances in cars, and it was not until the law obliged it that the change was made.

But at present, life has an economic value never before attained, and, appalled by the waste and wreckage of human life and limb, the world is turning anxiously to means for saving future generations.

We believe in democracy of knowledge as we do in a true democracy in all branches of life. For some years the medical profession, and under this term I include the profession of nursing, has conscientiously striven to spread among women practical and clear knowledge concerning cancer. A brief, clear description of the first symptoms of cancer has been widely circulated, posted in dressing rooms used by women, and such knowledge has been spread abroad in every possible legitimate manner. Many cases of cancer can be cured by immediate operation, and it is to attract the attention of women to their danger and their hope for relief that this knowledge is made public.

Knowledge concerning the toxemia of pregnancy, eclampsia, hemorrhage during pregnancy, signs and symptoms of abortion and premature birth and the complications developing during pregnancy should be given the widest publicity and women should be urged on the slightest indication of danger to seek reputable medical help. A plain, simple, dignified statement of the important facts of reproduction should be given to young persons, and this may well be done in schools. Popular journals should positively decline all communications upon subjects connected with childbirth which are exaggerated, sentimental and hysterical. Propaganda actuated by trade purposes should be repressed and nothing should be done to help the quack and the cheat. One cannot expect to do much with the population unless sound, practical knowledge is made common.

Better education for doctors and nurses is also essential. In this great improvement has been made and is still in progress. In the Jefferson Medical College of Philadelphia each student personally attends 12 cases of confinement beside his clinical and didactic instruction before graduation. He then, before entering into private practice, spends a year in hospital work in a hospital having a maternity department. Our nurses see and study from 35 to 50 cases of confinement, covering the range of obstetric complications, before entering upon private practice.

The midwife is an undesirable product of foreign immigration. Until, however, hospitals become more abundant throughout all parts of the country and prenatal work connected with hospitals can reach inaccessible portions of the country, it seems impossible to abolish entirely the midwife. She is far more strictly watched than formerly and with corresponding improvement in her work.

The necessity for prenatal care has of late become more definitely recognized and has been brought to the attention of the public. Balantyne in England has been instrumental in opening wards for pregnant women only and in establishing prenatal clinics. When one remembers that the toxemia of pregnancy is in many cases preventable, one can appreciate the value of prenatal care. How successful this may be can be judged from the Bulletin of the Department of Public Health and Charities of Philadelphia, February, 1917, in which Medical Inspector Dr. Florence Childs, from the Division of Child Hygiene, states that among 1736 prospective mothers visited by the city nurse during the year 1915, there was but one case only of eclampsia. To be most successful, prenatal care must receive assistance from social service workers. It is useless to tell a mother to take proper food when she does not know what it is nor how to cook it, and when she is unable to buy it. The economic conditions in each case are often most important. So too, the police department may also coöperate in arresting abortionists, closing houses of abortion and resorts of drunkenness and vice. All those agencies which make for decent, clean and honest living are vitally concerned in prenatal care. Women illegitimately pregnant should not be neglected in this regard and such a woman should be shielded and kept from abortionists and the life of the child as well as her own life should be saved.

While the interests of the mother are first, prenatal care has an enormous bearing upon the life and health of the unborn child. Deformities are usually produced during the early months of pregnancy and then it is that pregnant women are often sickest and more needing of attention and encouragement. As pregnancy goes on the dangers

to the mother increase in greater proportion than the dangers to the child. The child whose mother is ill-nourished during pregnancy will not escape the effects of her lack of foods. Children so born fall a ready prey to the infectious diseases and frequently die from pneumonia after measles or contract tuberculosis. Prenatal care may spare the infant the poisonous effects of alcohol in the mother or the blighting influence of poisons to which she may be exposed in various industries. So too, the sanitation of shops and factories is most important for mother and child.

Obstetrical science has gone forward rapidly in recent years in the development of obstetric surgery. Contracted pelvis and deformity has lost much of its terror for doctor and patient. Hemorrhage complicating pregnancy and parturition can often be promptly and successfully controlled by surgical means. In toxemia and eclampsia the results of treatment show a decided improvement. In the prevention of puerperal septic infection there is little if any improvement throughout the country, because so many of those who attend confinement cases will not scrupulously practise asepsis and antisepsis.

The most important factor in the diminution of death and disease among mothers and children lies in the development and increase of hospital care for women in childbirth. When the public and the profession believe and practise the truth that women in childbirth should have the same careful attention that a patient receives who must have a surgical operation, then and then only will decided improvement occur. By this we do not mean that obstetrical patients necessarily require obstetrical operations, but the act of labor itself frequently causes wounds and injury and such a case should receive the same thorough antiseptic and repairative care which is given to other surgical conditions. As the number of hospitals increases throughout the country, as good roads are made common and motor ambulances multiply, cases of complicated labor will more and more be promptly taken to hospital and will there receive adequate medical attention. The medical profession and the public must be made to believe that so important are these cases that they must receive as good care as that given to serious accidents occurring in factories, to cases of tumor developing in women requiring operation, and to cases where hemorrhage from other causes than pregnancy and childbirth threatens life. No substantial improvement can be made in obstetric mortality and morbidity until these facts are admitted and appreciated.

This matter takes us to the very roots of our national life. Nothing can so strike at the heart of illegitimacy in pregnancy as reform in economic conditions which shall give to young men and women a living

wage, good sanitation, reasonable and healthful amusements and the rights and responsibilities of a true democracy. Early marriage should be encouraged and made possible. The time may come when a medical certificate of good health may be demanded before a marriage license is issued and there are many arguments in favor of this course. No stronger means can be taken against vice and immorality than the encouragement of a pure and happy family life.

There is a lesson of deep significance in all this for those in this country who are favored with abundant prosperity. Luxury produces nervous, degenerate, feeble offspring and miserable health. Luxury sets false standards of life and creates unhappiness and unrest in those who do not rightly know the true value of things. Selfish and idle luxury is foreign to the genius of true democracy. The idle degenerate are soon pushed aside by the strong, the normal, the clean and the healthy, but still their influence is not for good.

The strength of a chain is the strength of each link and in the present world's crisis when the greatest storm of history is wrecking human life, it is our duty to see to it that our ship of state has an anchor chain of true democracy, whose links are healthy, sane, honest citizens. Such an anchor chain will hold from wreck against the tides of aggression and even internal conflict.

#### MEDICAL SOCIAL SERVICE: AS IT RELATES TO TRAINING SCHOOLS IN BEHALF OF STUDENT NURSES.<sup>1</sup>

By RUTH V. EMERSON

The reasons for closely affiliating the hospital's training school for nurses with its social service department are many and obvious, yet I should like to direct your attention to four of the more important to explain why at the Massachusetts General Hospital in Boston we have outlined a course which gives some instruction in social service to all of our nurses and is distributed over their three years of training.

*The first* is brought out in simple answer to the questions put by educators, "Are you interpreting the pupil's class-room work, his laboratory material, in terms of every day life? Are you relating his theoretical study to the practical problems of every day living?" If a nurse is to know the various aspects of heart disease she must know

<sup>1</sup> Read at Joint Session on *Medical Social Service*, Philadelphia, April 28, 1917. Other paper read at this session to be published in *American Journal of Nursing*: "As it Relates to the Economical Administration of Hospitals," Mary A. Cannon.

more than the medical-clinical picture; she must know also the social-clinical picture,—under what conditions her patient has lived and worked, whether his tenement is on the top floor and his work that of pick and shovel. She must realize that to think in hospital terms she must know the dialect of home and working conditions, so that the "No stair climbing, little exertion, good hygiene," will not be glibly quoted and handed to the patient as unthinkingly as the doctor's order for pill no. 6.

*Secondly.* As we are teaching our nurses the various curative and preventative measures of attacking disease as well as the functions of the various departments in the hospital, have they not a right to expect to learn the purpose and aims of that department which has been added because found necessary for the effective treatment of hospital patients? When, as graduate nurses they go to other hospitals how are they to know whether they want or need a social service department or how to connect with the social service department if it already exists? Should they not make these contacts while in training?

*Thirdly.* Increased opportunities are continually being opened to women equipped with social training and a teaching knowledge of health. Shall we not allow undergraduates to nibble at medical-social and public health work to see if they like the taste well enough to take definite post-graduate training along any of these special lines?

*Fourthly.* The fuller understanding of nurses and social workers is better for each, and best of all for the patient. The stimulus of having pupils in any social service department is something vital to the workers.

I do not propound these four reasons for the alliance of the training school and the social service department as new, for I know they have been acted on in some degree in a large number of hospitals, often through affiliation with the district nursing association. But I do wish to emphasize them as arguments for the use of the social service department as the vehicle for the nurse's insight into the social aspects of disease.

At our hospital we have such a relationship between the training school and the social service department and have outlined a course which appears in the training school's prospectus and which is given a definite place in the curriculum. The nurses are graded on their work and an examination given. This is important, as otherwise it would be like getting something for nothing,—an unsound policy in education. Not all of this course has been consecutively followed, but each section has been tried out and seemingly the results have been worth while, both from the student's point of view and from ours in the social service department. All of the nurses at the end of their three months'

probationary period have a series of eight or ten classes which are in part lectures, part recitations, but largely frank discussions. This is in contradiction to the outline suggested by your committee a year ago, wherein, you will remember, they suggested that each probationer spend three days in the social service department visiting various sections of the city, learning the peculiar community problems which may be responsible for sending patients to the hospital, getting something of the prejudiced points of view of the patients, for instance, the Italians and the Jews. Furthermore, your committee advised against any lectures until the third year.

I agree that the nurse's interest in her patient as a human being with varying responsibilities should be aroused as early as possible. Surely before she is institutionalized. But as I have watched probationers it seems to me that everything is so new to them and they are making so many re-adjustments that to give them any social interpretation of the patients would only add to their confusion. They may be more responsive when they first come, but I believe they had best get their impressions unaided and their feet securely under them before their minds are directed along social lines, for unless they do I believe there will be a real danger of sentimentality coloring their reaction. In one of my groups of twenty-four nurses, only five had had as much as a bowing acquaintance with Jews, Italians, Greeks, or other foreigners; only three had any idea of their points of view, save that Jews are forbidden certain foods. Talking with probationers about racial prejudices of the Italians before they had more than seen a few would be of little value, yet talking with them after they had helped care for several Italians on the ward, you can make vivid to them what a departure it is for an Italian woman in whose own country it is considered degrading to go to a hospital, to be a patient in one of our public wards and examined by a group of students. Furthermore, I believe talks, classes with discussions, even lectures need not be theoretical, stupid, or too deep for first year students. In fact I suspect that there will be much more give and take in such exercises with nurses in their first year of training than in their third year after their passivity has been cultivated and their ability to argue and express their own opinions has been stifled.

How much does the nurse know of the proper treatment of endocarditis, although she has cared for Maria Farraci on her ward for two months and has heard the doctor talk to the mother, who looks bewildered or smiles benignly when told she may take the child home provided she keeps her quiet, out of school, and lets her have good food, how much does she really know except that it has taken two months to clear up this acute upset? The child should have simple food and

needs restricted exercise, yes; she may remember, too, that unless these children are careful for over a long period of years they are likely to become grown men and women with serious heart lesions. But the nurse has no more idea of what it means to an Italian family, father, mother, and five children under working age, to care for a youngster with heart disease than the mother has of what the hospital has been doing to get her child well enough to go home, yet the home care of that child is very definitely a part of her treatment and furthermore, the nurse is supposed to be intelligent regarding the complete treatment of endocarditis. Her teaching has not been practical; it will not be applicable to human problems, unless she has an idea of the home life of her patients. Unless she has seen or heard described an Italian family in their home, has tried to persuade them to give up some of their lodgers who take beds the children should have, has explained to the mother, who has not an inkling of why her child, who apparently looks well and strong, has to be favored, unless she has a clear picture of these conditions, she cannot see truly the problems of the after-care of Maria.

After considering in detail these family problems she will appreciate more fully the difficulties, understand, and not be surprised at the reëntry of these children. As a nurse on the ward she will be more thoughtful concerning her opportunities to teach the child and the family while Maria is still in her care. In the adult ward where her cardiac patients are too often both handicapped workmen and hospital repeaters she will be more interested in the true significance of heart disease and more questioning as to how it may be attacked.

In our classes we talk over just such problems and stimulate each other to think of the patient not only as a hospital case with a diagnosis interesting to medical students and house officers, but also as a many sided human being with responsibilities to himself, his family, his work, and the community. Sometimes he seems almost to be a chameleon, but at the same time we try to see what it is that we owe him, what it is that he needs besides the hospital-bed, food, and medical treatment.

We use social service case records and together work out the necessary steps in the plan. We do not attempt any careful discrimination of social agencies but explain the function of the various ones as we meet them in working out our problems; for instance—in effecting the transfer of a woman with tuberculosis from our hospital to a state sanatorium we brought out our relations not only to the family and their relatives but also to the local Board of Health, the tuberculosis nurse and dispensary, one of our State Boards, the school nurse, and teacher, a child-placing society, the parish priest, and landlord. At the end of our discussion

the nurses had a pretty clear idea of what a diagnosis of tuberculosis really means to the mother of a family of young sickly children with an irresponsible father. They knew what kinds of things have to be considered and in how many directions one may need to travel to unravel a family problem. Furthermore, they learned how to start the ball rolling to secure adequate care for their patient. If they become hospital administrators they will have an idea of how to start to get rid of the pleurisy patient who is found to have pulmonary tuberculosis.

The schedule which we have is somewhat as follows:

*Lecture 1.* Background of hospital and patients admitted; reading of selected parts of the annual report of the hospital,—object of hospital medical and surgical classification of patients admitted (briefly), their nationalities, residences, and occupations.

Discussion of the various kinds of hospitals in the community; their purpose and how maintained,—hospitals for tuberculosis, chronic diseases, maternity cases, children's diseases; hospitals run by State, City, as private business or private charity. Hospital uses and distinctions paralleled with social agencies.

*Lecture 2.* Reasons for organizing social service: changes in medicine—passing of the pill box régime and dawn of the personal hygiene era. Crowded industrial conditions. Passing of the family physician. Individual disease now a question of public health.

*Lecture 3.* Presentation of case of a tuberculosis patient.

*Lecture 4.* Presentation of case of a child with heart disease.

*Lecture 5.* Presentation of case of a child with eczema.

*Lecture 6.* Presentation of case of a feeble-minded girl.

*Lecture 7.* Presentation of case of a man with cancer.

*Examination.* Eligibility of patients for admission (in detail). Steps and plan for care of girl with chorea and heart involvement. Plan for old lady with fractured femur and cast, etc.

From time to time questions are asked and the answers written out and handed in before class; for instance: "What would you do if the doctor asked you to find a boarding place for a young immigrant who was on the ward because of a fractured spine which occurred in the mill where he worked?"

Along with these talks or after they are completed we have the nurse visit patients' homes, patients whom we know will be glad of visitors; baby clinics, settlements or other social agencies, for example, an associated charities conference. Because these visits should be in small groups, preferably accompanied by a trained social worker, and usually taking half a day, we have not carried this part of our program as far as we wish. We want each nurse to have six such half day visits be-

sides one whole day with the district nursing association, which in Boston is a separate organization not connected with the hospital. These visits should not all be made in one week and after them there should be time for discussion and explanation.

When these two sections are completed we expect the nurse to have a working knowledge of why we exist, and of what kinds of things we attempt to do. It is the policy of our social service department to accept cases referred to us by pupil nurses. The head nurse should be consulted before a case is brought to our department, but one of the other nurses is free to come, and she often does. In the dining-room nurses have been heard discussing whether "so-and-so" ought not to be referred to Social Service because she has nowhere to go when she leaves the hospital except right back to work, and she is a scrub-woman with varicose veins; or "Should not Social Service visit to see who is looking out for Mrs. J's. children, all of whom are under twelve, and she is so worried about them that she has not slept decently for two nights?"

*In the second, Junior, or Intermediate year*, call it what you will, we plan eight one-hour lectures putting before the pupils the social side of the diseases which they are studying in bed-side clinics. These lectures are not always in the class-room, but may be in the out patient clinic.

Besides this required work nurses are assigned to two of the out patient clinics for three months; one to the syphilis clinic, the other to the children's. In the morning they act as nurses and in the afternoon do social case work under the supervision of the social worker who carries the cases in that clinic. I believe that this is a sound policy which can be advantageously extended to include other clinics, for instance, the orthopedic, male and female medical and surgical clinics. It has a fair balance of nursing and social experience as related to a certain group of diseases.

*In the Senior year* we have four lectures presenting the field of public health nursing and medical social work. These are in the nature of vocational guidance.

In addition to this, four nurses a year are chosen to spend three months in the social service department. They are on the wards as nurses on Sundays, and do have occasional lectures, but except for that give their entire time to our department. Two months are spent in the out patient and one in the ward social service department. The reason for this division of time is that we feel the out patient department is less familiar to them and that doing social work there will be a greater jolt and more stimulating than to begin in the ward social

service office. Furthermore, in our hospital social service was started in the out patient department and the relation to the training school established before we had a social worker in the wards. During this three months the nurses always have close supervision but work up from carrying minor responsibilities to full investigations, mapping out plans which they themselves carry through. They arrange sanatoria care for tuberculosis patients, convalescent care for others, have experience with skin diseases, observe the relation of industry and disease, make plans for a run down mother to secure an operation, visit various institutions and social agencies. Prescribed reading goes hand in hand with this practical experience and the nurses attend a weekly conference on social case work.

There is also an elective in public health work which is two months training with the Instructive District Nursing Association; two months post-graduate work may be taken which will give the nurse her certificate. Occasionally the entire four months may be taken during the three years of training.

Too great stress cannot be laid on the importance of choosing with the greatest care those nurses who are to have these opportunities for intensive social work. Introduced to social work in her first and second years any pupil should know by her senior year whether the more social forms of nursing appeal to her, and the training school ought also to know who is best suited to try out along social welfare lines.

Thus far we have concerned ourselves with the need of, and advantage to, the training school by allying itself with the social service department. I want to state my conviction that the gain on our part by such a welding together is something very real. By understanding each other better we are sure to get on more happily and so work more smoothly and efficiently. But, greater than this is the reaction brought by the questionings and challengings of the pupil to the social worker; this is bound to mean clearer thinking and consequently better case-work.

Our social service schedule, which you see, covers the nurse's entire period of training, giving her first a glimpse and later offering her considerable experience in social work, has been outlined in connection with a thoroughly equipped training school which has a carefully planned curriculum, and a social service department with workers qualified to teach. These two states of well-being ought always to go hand in hand, but because we all know that they do not, I should like to suggest various adjustments which seem to me feasible.

In many instances the expenses of the training school, the hospital, and the social service department are made up in three separate budgets.

It seems to me fair for the training school to share with the social service department the cost for the social teaching of its nurses. If this is a legitimate part of the school's course why should there not be one worker in the social service department who would also be on the training school teaching staff? The head worker, ex-officio should be the connecting link to help plan the course, but she need not be the teacher nor the person whose salary I suggest should be paid in part by the training school and in part by the social service department. Many social service departments are unable to give the kind and amount of teaching which nurses should have, yet if the funds for a social worker with teaching ability were procured in conjunction with the training school I think it might often be arranged.

In the case of hospitals situated near the various schools of social work or philanthropy, an affiliation might be made for several training schools to have a uniform course under the school's auspices.

In line with this is the course of lectures which Miss Evans has been giving this winter in Cleveland and the talks arranged here in Philadelphia.

These and the papers in your **PUBLIC HEALTH NURSE QUARTERLY**, by Miss Beard, explaining the different branches of public health work seem to me very valuable, and I should think might be used as teaching material. An objection at present to them, and it may not be an objection but only a limitation in them, is that they are too closely tied up with the field of actual nursing and do not give any conception of other medical social problems. This is, of course, just the difference between public health nursing and medical social case work, but I do feel that the nurses need a glimpse of both.

At present there is a great lack of medical social service literature in this form, but I hope we may soon have some and, also, that we shall have medical social case records published in a form suitable for teaching. Probably many of you are familiar with the case histories published by the Charity Organization Society in which the case record is disguised but the facts kept. There are breaks made in the records that one may stop and discuss the problems as they develop and yet not see ahead to know how things are coming out.

To give our pupils social experience could we not have affiliations with other hospitals just as we do between general and maternity hospitals? Could not hospitals having a course somewhat in line with the one we are having receive for three or four months nurses from other schools?

Here again may I repeat the tremendous importance of carefully selecting the nurses for this special training? Though I am convinced

that there is a minimum of social interpretation without which no nurse should be trained either for private or institutional work, I believe just as firmly that several months of practical experience need not be given, at the present time, to every nurse. We must remember that in three years we cannot graduate both a trained nurse and a trained social worker, unless we change in quite radical ways the training school curriculum; but in three years we can give every nurse an opportunity to know something of medical-social work and can start on their ways those nurses who expect to continue along special lines.

### HOW AND WHERE SHOULD ATTENDANTS BE TRAINED?<sup>1</sup>

By EDITH M. AMBROSE

#### INTRODUCTORY

It has been said that a new truth is only an old one risen from the dead, and we probably all realize that this demand for attendant nursing service is as old as the existence of evil. The lamp of knowledge is simply shedding a new light on the old laws of cause and effect, supply and demand.

The recognition of the fact that all disease is preventable has led us to believe that it must be made a working principle for the majority if our ideals of health for all are ever to become a reality. Efficiency in a machine can only be obtained when the operator is familiar with the principles of his machine and the laws which govern the medium in which he wishes to operate it. For example, an aviator who would attempt flight without knowledge of his machine and the laws of the air would quickly pay the penalty of his ignorance; he might fall on fifty innocent victims and cause the death of the entire fifty. So one ignorant or careless individual might cause the death of many who were observing these laws. It is this knowledge and the recognition of its value to the entire community that has given birth to the desire to have it reach the majority and has created the demand for an agent who can come into contact with every individual in the community with the message of health at a time when he is most ready to receive it. The most logical person to answer this demand is the public health nurse. It has called from our ranks already 6000 of the 70,000 regis-

<sup>1</sup> Paper read before Joint Session on "The Training and Status of Attendants," April 30, 1917. A further paper read at this session to be published in *American Journal of Nursing*: "Is There a Need for Another Class of Sick Attendants besides Nurse?" By Frances Stone.

tered nurses and previous to this drain the public were insistently calling for more nurses, nurses who would answer every need, who would care for the sick who were able to pay moderately but who were quite unable to pay the high price demanded, rightly enough, by the highly trained nurse. Several attempts to meet this demand for more and cheaper nurses have already been made, and how and where this is being done it is the purpose of this paper to discuss.

The nursing profession has been slow to recognize this need and reluctant to face the truth concerning it. They have even shown a spirit of veiled antagonism toward it. Attempts have been made by physicians and others to meet it, attempts which if allowed to go unchecked or unregulated bid fair to lower our standards of service, which we have been at such pains to build up.

The question at this moment assumes an attitude of vital interest because of the impending health insurance legislation and unless it is answered and answered adequately by the nurses themselves it will be answered by the public, the government, the medical profession, and others, and between them our cherished standards will receive little attention. The law will demand nursing service for millions for whom it has never been available and unless we are prepared to meet it, and well prepared, it will be passed over to more capable hands and ones who care little for our ideals. If therefore we can present plans that will prove, to the satisfaction of the public, that we can offer expert supervision and adequate care for the sick, at a price within the means of the agent who is obliged to pay for it, we may consider our proposition proved.

#### NEEDS

Miss Eleanor Rathbone of Liverpool said in 1889, in connection with this subject:

Last winter at a time when there was a great deal of serious illness and the doctors were telephoning from one institution to another to find a disengaged nurse, we happened to hear of two neighboring families who were employing Royal Infirmary nurses—one to nurse the footman and the other a child, both suffering from a slight attack of measles. A sick room helper would have done the work not only as well but better, since she could have cleaned the room and waited upon herself. I am aware that most nurses, or nursing institutions, do occasionally employ help for cases of this sort. They know of women that can sit up at night and do everything else that our sick room helpers do. I only suggest that the need should be definitely recognized and provided for as an auxiliary to district nursing, that a regular suitable woman of ascertained qualifications, willing to work under fixed conditions, and rates of pay, shall be kept either at a home or by some outside body, and last but not least that the cost of employing

them shall be defrayed when possible by the patient's friends, but when not possible that it should be met out of the institution's funds.

It is somewhat doubtful whether in these days of subdivision of labor it is altogether satisfactory to try to combine in one and the same person the highest skilled work and the roughest manual toil, and it is obvious that if you pay an individual who discharges these dual offices on the basis of her skilled work you greatly overpay her for her manual work, and vice versa. It should not be beyond the power of good organization to devise a scheme by which, where necessary, the rough housework is done by the "handy woman" and the skilled nursing by a skilled nurse.

Miss Rathbone in these sentences has shown that there was at that time in England a definite need and demand for this class of service. It is fundamentally the same in this country, except that our methods of training and our attitude towards life are a little different and so we must approach the problem from a slightly different angle. "The world lives and grows by heresy and treason, it dies by conformity to error and loyalty to wrong," said an inspired writer, so let us face the question squarely, let us not be loyal to any error that may have crept into our ideals of the standards which we have set, let us rather make a standard for the work that each group is undertaking, a standard for the workers in each group and clearly define our groups. Let us fearlessly face the truth and arrange our work in accordance with its principles. The truth is:

*First.* That we need two kinds of nursing service, that of the skilled educator, and that of the less skilled worker.

*Second.* That they are for practical purposes an impossible combination in one person.

*Third.* That they are both necessary at the same time, one for educating the patient and her friends at the only moment when the lesson is liable to be effectual, and the other to do the work which requires too much time for the skilled worker to give.

The care of the sick, if left to the chance kindly neighbor is liable to be left undone. How many have no neighbors in the city? Neighbors sound well and call up a pleasant emotion, but they are seldom experienced in real life and it is realities we must face.

*Fourth.* That a large majority of the public can pay for nursing but cannot pay the price of the Registered Nurse.

The greatest truth of all is that whether we wish it or not, whether our standards are maintained, lowered, or altogether lost, makes not a particle of difference to the demand of the public for increased nursing service. We have *got to meet this demand* if the Health Insurance Bill, which includes nursing among its benefits, becomes a law. The question comes right down to the one that has been agitating the public mind

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for the last three years, are we going to be prepared or are we going to "watchfully wait" until the matter is taken out of our hands?

To show that these needs which we have enumerated are especially applicable to the rural community, let us refer for a moment to the Dutchess County Survey of 1912. A house to house canvass of four typical townships shows that 1600 people were seriously ill in eighteen months, that 90 per cent of these remained in their homes during the entire period, and that 78 per cent of these could have been adequately taken care of in these homes if there had been available medical and nursing service. It also showed that this lack of care was not due to poverty. Of the 113 women who went through childbirth in their homes, only one had the continuous care of a graduate nurse, and only 18 had any care whatever from graduate visiting nurses. Is this demand of the public unreasonable when in one of the most favored counties of this state, if the proximity of rich neighbors and a large city are looked upon as favors, 78 per cent of the sick are suffering unnecessary pain and loss through a preventable cause?

### OBJECTIONS

The objections to training attendants in this country are: That we are preparing to call into existence an inferior class of practitioner who may usurp the functions and title of Registered Nurse. This is much the same argument that was used by the physician against the midwife's bill, that no recognition or encouragement should be given to the midwife's training because every confinement should be attended by a physician. The answer is the same, that the great majority cannot afford and ought not to be compelled to pay for highly skilled and remunerated service when they might secure services which would answer their needs for a less price, also that the less skilled would be more likely to keep within the limits of what they could rightly undertake, if they were responsible to and working for a society rather than as free lances.

The second objection is that we are taking one more step to breaking down the motive to neighborliness among the poor, and that everything the sickroom helper does for the sick can be and usually is done by the family and friends. In reply we might ask, if this spirit of neighborliness is sufficient training to care for the sick poor why is it not equally desirable for the sick rich, and if so why do we train nurses at all?

A third objection is made of the difficulty of raising funds adequately to carry on this work which is bound to be inadequately paid for.

The answer is that the most economical way to treat the sick is the way that cures them most quickly, no matter what the cost. The

employment of nurses in industrial and insurance companies testifies to this fact.

The question of legislation and the objection to having the attendant included in the same class as the registered nurse is also a great stumbling block in the minds of many.

In my opinion, the time for the regulation of attendants through legislation seems to be hardly ripe. Before bringing the matter to the legislators we must establish some recognized standards. Legislation simply means the protection of the public in much the same way that the naming of any article does. For example, "the fact that margarine may not be sold as butter does not force the purchaser to give up butter and live on the cheaper article, all that it does is to protect the customer of indiscriminating taste from paying for margarine believing it to be butter." What we expect in the main from legislation is that the public shall not mistake the attendant for the registered nurse and pay her the same price as the latter is qualified to command. We want a way of distinguishing ourselves so that the employer who wants a thoroughly expert nurse may not inadvertently engage one who has not the qualifications essential to the purpose.

For this reason, we must have certain fairly fixed standards for both classes and until those who have undertaken the work of training these women get together and thoroughly cooperate from the beginning, this cannot be accomplished. Our efforts for the present should be confined to keeping the attendant out of legislation for nurses, we should object strenuously to having them called "certified nurses," or any brand that would tend to confuse the mind of the public. This objection on our part is quite as valid as that of the medical profession when they insisted on having the midwives registered in a class by themselves instead of as maternity doctors; the confusion in the mind of the public in our case is even more real.

#### ENGLISH HISTORY

The training of the cottage nurse, as the attendant nurse is called in England, began in 1882. The practical instruction was similar to that given in the best thought-out courses in this country, not including attendance at serious operations or such surgical cases as could not be treated in a laborer's cottage, but embracing maternity nursing pre- and post-natal. When Sister Catherine began the training of these cottage nurses, a deputation representing a body that thought itself very influential was sent to attack her on the iniquity of giving training in a district rather than in the wards of a hospital, but within twelve months that same influential body was sending down some of its nurses

to be employed and trained as village nurses. In 1888 the Rural Nursing Association, started in the west of England, was the pioneer of the system of County Nursing Associations. The first of these formed was in Hampshire in 1891, followed by Lincolnshire in 1894. Wherever possible, nurses with full hospital, district and midwifery training were employed. For areas where neither work nor funds permitted the support of such nurses, village nurses (trained as midwives and in elementary sick nursing) were supplied at a fixed rate of remuneration. The Queen's Institute requires the appointment of a Queen's nurse as County Superintendent who shall be responsible to the County Committee for the adequate and constant supervision of the practical work of their nurses.

A study of the present methods of training attendants in this country reveals a lack of any fixed standards. They all agree that some training is necessary. Some think that their work should continue under supervision of the graduate nurses, others see no necessity for it. Some think no hospital experience is necessary and others that no home or field experience is necessary. Some require a tuition fee and the pupils to pay their own living expenses, others provide the living and charge a tuition fee, notably the Thompson Schools. By the Thompson Schools I mean the Lynn and Rhinebeck and affiliated centers. Some large hospitals for chronic cases are offering a sliding scale of wages which begins at \$12 and reaches as high as \$18 a month. It is expressly stated, however, that this is not to be thought of as remuneration for services but only for textbooks and uniforms, though why the need for uniforms does not remain uniform is one of those unfathomable hospital mysteries, and one can hardly be blamed for imagining the increase was because the hospital authorities considered their services more valuable in the last six months. The length of training seems to be a very disagreeable point, the time ranging from a minimum of eleven weeks to a maximum of eighteen months, while one center requires two years on its registry with six months actual training.

The correspondence schools I shall not discuss, for it is obvious that anyone who attempts to teach by correspondence a practical subject calling for actual practice as a mark of efficiency, proves itself worthless at the start.

The training center idea, with the advantage of a small hospital of eight or ten beds, such as the Thompson group offers, while better than practice with a mannikin, does not provide the pupil with any opportunity to observe a number of patients suffering from the same form of acute or chronic disease, nor does she have the advantage of familiarizing herself with the use of sickroom appliances on any con-

siderable scale, when her hospital experience is limited to a few patients for a period of four months.

It is argued that the women who go for this training are women with more or less experience in both household work and the care of the sick, and that therefore they have been partially trained before they begin. This argument may hold good with a few, but must we not look ahead to the probable passage of the Health Insurance Bill which, when carried into effect, will call thousands into this work who otherwise would have gone to the shop or factory? They will become candidates for this field of service and their youth will preclude the possibility of their being experienced in either of these occupations. The question is, then, will six months be sufficient time to teach them the things they must know to be of any value whatever? We shall want them to understand plain cooking and to a certain extent the buying of food and the providing of a diet which will be at the same time nourishing and economical. They must know how to do ordinary housework in order to assist in it if necessary, how to care for the children and feed the baby, how to give the patient a bath, take the temperature, pulse and respiration, and do simple recording, and the keeping of notes, which means a training in observation and practice impossible to get in a small hospital. They must know how to make and apply poultices and stupes, give douches and enemas, bandage simple wounds, put on maternity binders, how to avoid bed sores and to give the simple massage necessary for bedridden patients. They must also understand the care of the sickroom utensils, and disinfecting of clothing, etc.

It seems as if we were attempting to put a great deal into this six months. Plain cooking and the household work and buying would almost require this length of time. It might be urged that they will continue under supervision and that the training would go on indefinitely. Not if I am any judge of human nature! Back we must come to the truth, which is that the majority of patients will object to being used as subjects for training our pupils on, and that it would require a larger staff of supervising nurses than we shall be able to have for such an intensive teaching. And moreover, the pupils themselves will object to unending lessons unless the teachers are unusually tactful.

The chronic hospital, while offering a varied experience in the care of the patient and the preparation of his diet, lacks the opportunity for experience in the rural or city home. At the same time it runs the risk in its course of eighteen months continual hospital work of turning out practically a trained nurse without the education to realize her limitations, and one who would probably be unwilling to assist in

any practical care of the household. She will resent supervision because the hospitals do not consider it necessary or, if they do approve of it, have no way at present of securing it and have not trained all to expect it.

From the foregoing, it would seem that possibly the ideal training would be one that combines the advantages of the large hospitals for chronic patients with training for an equal period under the close supervision of the public health nurse in the rural district, or the visiting nurse associations in the city, depending on where the pupil intended to continue her work. It has been argued by some that the attendants need no home training if they have had a chronic hospital course—we might as well argue that the public health nurse needs no special training for her work, that her hospital work will fit her for any emergency. Those who advance this argument should put a graduate, fresh from the hospital, on duty as a public health nurse in a rural community and watch her for six months. The attendant certainly does, in my opinion, need the field experience for either city or rural work.

The course being tried out by the Dutchess County Health Association differs from the others in that it combines experience in the large hospital for chronic patients with an equal period of training under the supervision of the Dutchess County Health Association, of Dutchess County, N. Y., and the public health nurses in rural communities. Its affiliation with the Montefiore Home Hospital gives its pupils an opportunity for varied experience. This hospital contains 450 beds for chronic patients in its wards and a private pavilion of 50 beds. It also offers an elective course in tuberculosis nursing in the Bedford Hills Sanitarium. The experience in the care of the chronic patient, with especial emphasis on massage and baths, is exceptionally valuable. An opportunity is here presented for the attendant to see many cases and meet many situations which would be denied her in a small hospital whose capacity was limited to eight or ten beds.

It has been objected that the attendant, after this experience, would be dissatisfied to continue her work in a rural district. This objection cannot be answered from experience at present, but we feel it to be a remote possibility in view of the six months of field training under the rural public health nurses. It is hoped that during this period the attendant will establish such friendly relationships among the people with whom she is thrown that she will decide definitely to settle in their midst.

Moreover, the six months of close supervision which the public health nurse with whom she is associated will exercise over her will tend to form a habit of supervision and create a desire for its continu-

ance. If her supervisor is tactful and capable, the attendant will readily realize the value of supervision and will have no desire to work in a place where it is lacking.

The Dutchess County Health Association hopes eventually to provide living accommodations for a certain number of attendants at its center, after they have finished their course and while on the waiting list. This would bring them to the center more or less frequently, where efforts would be made to keep up their interest in the work as a whole. Stimulating talks will be given to them from time to time with the object of creating a spirit of fellowship among them and with the staff nurses, so that they will take pride in their own branch of service and endeavor to keep their work up to the standards which they themselves will help to create. A certain number of the most valuable ones will probably be put on salary by the Association in order to retain their services for the Association, as well as to keep their influence among their associates in the work. The value of this plan should appeal to all who have experience in any work which has to do with groups of women.

#### CONCLUSION

In view of the fact that both large chronic hospitals and visiting nurse and health associations seem to be logically necessary in the training of attendants, my closing suggestion is that a plan be worked out in detail whereby these two would combine and coöperate in such a way as to offer a somewhat shorter course in the hospitals for chronic cases than they now require, supplemented by a three or six months course under the tuition of the nursing centers. The centers could then combine to control the registries for this class of service and would thus regulate both supply and demand. If all candidates for this work were sent to the hospitals, the hospitals might in turn agree to have their teaching and training in the wards done by registered nurses. Two classes of training might be offered, one leading to continued work in institutions, and the other as assistants to public health nurses in the rural communities, or in the same class of work for visiting nurse associations in the cities.

This plan, if developed, would do away with the awful bugbear of the "invasion of our rights," and "lowering of our standards" for it would give the control of the entire field into the hands of the nursing profession and would work for the common good of the registered nurses, attendants, and public.

A HEALTH CENTER IN A LARGE CITY<sup>1</sup>

By ROBERT H. BISHOP

It is rather difficult to say just when health centers, if you can call them such, were first developed in Cleveland. In fact I find some difficulty as I begin to write about our work to define just what a health center is. I have read carefully practically all that has been written on this subject and as near as I can judge every community is taking the liberty of defining a health center.

In one instance we see an effort to do an intensive piece of work in the prevention of tuberculosis in a circumscribed area; in another an attempt is made to carry on an intensive piece of work in the prevention of infant mortality. Here you have specialized groups of nurses, there you have generalized nursing and the generalization of the nursing work is nowhere the same.

There is more or less agreement that a health center shall operate in a definite district with a definite population, but there is no uniformity even in this respect.

It is high time that some effort be made to standardize this work so that we shall know what each of us is talking about, so that we shall have a basis for comparison of results and costs. Most important of all—and this to my mind should be the guiding thought in the development of health center work—the plan should be blocked out and made operative first and last from the standpoint of health administration on the district plan. The time has come when each community in this country should begin to shape up its public health work; it should take on form and develop efficiency and thoroughness.

It is time that all private organizations should be getting together and thinking in terms of the community. They should as a group plan the health department of their city. Enough time and money has been expended upon experimentation. It is clearly seen that tuberculosis, infant mortality, venereal diseases and all the rest are public health problems. Put your health department at the head of the line, fall in behind and in ten years' time we will see results that we do not now dream of.

Cleveland has put its health department at the head of the line. It has cost money—the money of private organizations to do this; it has

<sup>1</sup> Paper read at Joint Session on *Health Centers*, Philadelphia, April 30, 1917. Other papers read at this session, to be published in *American Journal of Nursing*; "Health Activities of a Civic Center in a Small Community," Elizabeth Ross; "A Country Unit," Wm. C. White, M.D.

cost time and effort on the part of a great group of private individuals, but it has been worth all it has cost and is beginning to pay dividends.

We are now in the fourth period, chronologically at least, of our development.

The first period, prior to 1910, was a period in which private organizations initiated work in the prevention of tuberculosis, infant mortality and general nursing work.

Working under separate organizations nurses were trained and employed in the various fields of activity. Dispensaries were established, surveys were made and a general appreciation of the size and needs of each individual problem was arrived at. You are all familiar with this phase of the work and I dare say most of you are in it now.

As a result of this work the question was being asked, Where is all this leading us?—the problem is so great we can not supply enough nurses or establish enough clinics to meet the needs of the community as a whole. What is the answer? The answer was given by a group consisting of all those interested in each particular piece of work which had been developed up to that time. The answer was—we must seek for the development and financing of the local health department in order that it may take over these various pieces of work and out of public funds support them and develop them to meet the needs of the community as a whole.

In coöperation with the city officials a reorganization of the health department was undertaken and two new bureaus were created—the Bureau of Child Hygiene and the Bureau of Tuberculosis.

The second period, beginning with the year 1910 until June, 1915, was a period in which these two new bureaus were developed under public control and largely with public funds.

The working forces of each private organization were incorporated in the new bureaus so as to insure the success of the work from the start.

The private organizations were ready and willing at all times to supplement the work of the bureaus by providing nurses, paying rent for dispensaries, buying supplies, until such time as public funds were available.

There was failure in one respect at the beginning, for while each bureau adopted similar schemes for organization,—that is, the city was divided into districts with a dispensary and a working force in each district, these districts were not uniform nor did they conform to the districts established by the private organization doing general nursing work nor those established by the medical inspection department of the Board of Education. There was no geographical or population basis for comparison of results, a condition which resulted in confusion and uncertainty as to the problem as a whole.

During this period the work extended rapidly, 15 prophylactic child hygiene clinics were established and 35 nurses employed. In the prophylactic clinics only well babies were cared for; sick babies were referred and treated at the Central Dispensary operated by a private organization. There were seven tuberculosis clinics with a force of 30 nurses.

About this time, early in 1915, the question of generalized nursing began to be discussed. Without going into the pros and cons of this question, with which you are all more or less familiar, suffice it to say it was decided to take one district of the city and try it out. Accordingly in June, 1915, a district with a population of approximately 100,000 was chosen, the tuberculosis clinic in that district became the center. A district supervisor was put in charge of a force of six nurses and made responsible for the tuberculosis, general and contagious disease nursing. Some months later the child hygiene nursing work was added.

The district was subdivided and a nurse placed in charge of each subdivision. The entire work of the district, in so far as it concerned medical and nursing service, was headed up in one central building. All clinics were held here—the general medical clinic in charge of the district physician (clinics daily); the tuberculosis clinic in charge of part-time physician (four afternoon and one evening clinic); the prophylactic child hygiene clinic in charge of part-time physician (three mornings a week).

There were problems of adjustment and difficulties of many kinds, but the work developed nevertheless. There are figures as to the volume of work, but they do not mean anything for we have nothing with which to compare them. We do know that after eighteen months of careful watching and study of the contact of the nurse in the district with the various types of cases, of handling of the family problem instead of the individual, of the ease and greater efficiency in administration, we were convinced that general nursing was practical, that the principle of health administration on the district plan was the correct and only efficient one; and on February 1 this year the health department organization was changed to conform to the district plan.

The city now is divided into seven health districts. Each district has approximately 100,000 population. The work of all the bureaus, as rapidly as possible, is being made to conform to these districts.

A new bureau has of necessity been created—the nursing bureau, the chief of which stands on a par with the chiefs of all the other bureaus. She is responsible to the commissioner of health, in joint conference with all the bureau chiefs, for the development and application of the nursing work to each health district.

Each district has a centrally located dispensary in charge of a nurse, known as the District Supervisor, and a working force of from six to ten nurses, depending upon the character of the district. Each nurse is responsible for a subdistrict. The nursing work in each district is developing along these lines:

1. General nursing (this only in one district).
2. Tuberculosis (in all districts).
3. Child hygiene (in all districts).
4. Venereal disease (in all districts).
5. Contagious disease (in all districts).
6. School inspection (in all districts—in parochial schools—this is separate from the school inspection in public schools).

The general nursing work, outside of the one district referred to, is conducted by the Visiting Nurse Association. This work will be extended to all the districts as rapidly as we can increase our field force of nurses. This particular service calls for an expenditure of more time per case than any of the others. We found, too, in our experimental district that the general nursing work increased much more rapidly than any other, which is explained by the more thorough contact with the district and the more frequent and regular service. This phase of the work varies considerably during the different months of the year and of course varies in amount in the different districts.

The tuberculosis nursing work is highly developed in each district. Bed side care is given to all bed ridden cases. Positive cases are visited at least every two weeks and contacts once a month. The great majority of private physicians' cases are cared for in the same manner as the dispensary cases, the nurse working in coöperation with the private physician and under his instructions.

The child hygiene nursing was the branch of nursing service that it was thought would suffer through the general nursing service. This has not been the case. We have an absolute check on this end of the service in so far as an initial call upon a new born babe is concerned.

The Division of Health issues to each new born babe a health certificate; these certificates are delivered in person by the nurse. A personal letter from the Mayor of the city is also delivered to the mother congratulating her upon the new arrival and advising her of the need of careful medical supervision, which the city provides in case she has no private physician. The nurses find that these certificates are of great value in securing admission to the home and in establishing a friendly working relationship with the mother. They have been the means too of increasing our birth registration, which is far from perfect even now.

The mothers are urged to bring their well babies to the prophylactic dispensaries, which are located either in the central dispensary or in the district, as the need may be. Sick babies are taken or sent to their private physician or to the sick babies' dispensary centrally located in the city. Here the expert physicians in charge examine the baby and the orders are telephoned to the central dispensary the same day; a written copy of the orders follows in the morning mail.

In venereal diseases what we call prophylactic clinics have been established in each one of the health centers. The city is placarded with signs calling attention to the need of medical attention in such cases and referring the cases to the city dispensaries. Upon their arrival at the clinic (and there are four afternoon and one evening clinics) the physician makes a preliminary examination, obtains name and address and refers the case, if it needs treatment, to one of the special genito urinary clinics, of which there are three in the city; or, if the patient can afford it, the case is sent to a reputable private physician. The nursing service comes into play only when the case fails to show up at one of the treatment clinics.

In contagious diseases the nurse is responsible for placing quarantine, instructing the family, also for taking of release cultures in diphtheria and removing quarantine and supervising disinfection.

We are hoping big things in this particular field of nursing work, for if there is any one phase of public health work about which there is more general misunderstanding than there is about contagious disease, I do not know what it is.

The instruction that was given in times past by the sanitary patrolman was little or none. Now the nurse spends time in teaching the mothers and members of the household concerning methods of infection, the dangers under certain conditions and the need for personal cleanliness. She concentrates upon the individual with the disease and makes him see the danger that he is to the community.

In school inspection work the same system is being developed as has been in operation in the medical inspection department of the public schools. The nurses visit the parochial schools, assist the physicians in their inspections and examinations of the pupils, give health talks and make such home investigations as are necessary.

We have found it necessary to continue one group of nurses to do special work. This group of three nurses and a supervisor has charge of the midwives, the adult and infant eye work. Later, when our force is enlarged, the eye work may be put on the district basis.

That a nurse is capable of doing general work we are demonstrating every day; it is being demonstrated elsewhere too, but it goes without

saying that she should have preliminary training. This was early recognized as essential in connection with each special piece of work. This has been provided for in a very thorough manner in Cleveland. Under the old scheme the different groups chose any section of the city they wanted for training purposes; now a definite section of the city has been set aside. The health department has no responsibility for it and in the district all training of nurses in every branch of public health nursing is here conducted. This district is known as the University Training District. The School of Applied Social Sciences, Western Reserve University, has absolute control of the work; the supervising nurse is a member of the faculty of the above mentioned school. She has a staff of four or five experts in various lines of nursing work. The work is planned and laid out with every thought for the benefit of the students and at the same time they are responsible for the nursing work in the district as a whole. Here all experimenting will be done and as fast as this or that method is found to be practical it will be applied to the work in our districts. In other words, this group of experts will set the pace for all the rest of us. The graduates will be placed in the health department districts as fast as they are available.

You are wondering about the connection with the relief agencies of the cities—how do they fit into the scheme? At the present time the Associated Charities, a private relief agency, covers the city on a well organized district basis, there is splendid harmony and coöperation but unfortunately the districts do not correspond. One of these days, however, the municipality will extend its work along these lines and the districts then will conform to the health districts.

The dispensary work in each district will develop gradually, as the Division of Health is able, through the possession of funds, to take on new functions, into general medical and surgical clinics. Prenatal work must soon be added, mental hygiene and dental clinics also, and it is our hope and dream, as these centers become general clinics, that there can be developed one big central clinic to be under the supervision of the medical school, with the full time professors in charge of the various departments in charge of the clinic work. The students would be assigned to work in the various departments of this clinic and also to work in the health centers. The full time bureau chiefs and also the full time district medical officer, who will be in charge of all public health work in each district, will constitute the staff of the school for health officers in the University.

In other words, it is our hope that the Health Division may be so connected up with the University that the municipality may have the services of all their valuable full time men of science—that also through the University connection better men and more permanent men may be made available for full time service in the health division.

It is hoped too that the services of such a diagnostic clinic can be made available for the private physicians, and that cases can be referred for diagnosis—and, more important still, that the great middle class of people who, for various reasons under the present scheme of things, are denied dispensary service may avail themselves of its services for a nominal fee and that then in the light of a thorough expert examination, which is out of their reach at the present time for financial reasons,—and, I might add, for the reason that the average physician has not the time or ability to render it—in the light of such an examination, the case may be returned to the private physician for treatment.

There are immense possibilities in the health center. It is right, absolutely right, from the standpoint of health administration. The organization is workable, it is elastic and with it in operation we will be better able to view the problem as a whole. We will be better able, as we see seven separate and yet similar problems clear cut and outstanding, instead of feeling an overwhelmingly large community problem, to place our attack and inspire our workers and, I am sure, obtain results.

## TEACHING PROBLEMS OF PUBLIC HEALTH INSTRUCTORS<sup>1</sup>

By ANNE H. STRONG

Of all the problems confronting public health instructors just now one problem is of prime importance. I wish to discuss it this morning, passing over, though with regret, other more technical ones that I had intended until a few days ago to bring forward at this time.

Every thoughtful woman in public health work sees on the one hand enormous need of the work that nurses can do, not only to save life, but to increase the physical efficiency of the nation; on the other hand, she sees the totally inadequate number of nurses already trained for public health nursing, the prospect of greatly increased need in the future, and the possibility of greatly decreased numbers of women preparing to meet it. Today each one of us is asking herself the same ques-

<sup>1</sup> Paper read at Joint Session on *Problems of Teaching*, Philadelphia, May 1, 1917. Other papers read at this session, to be published in *American Journal of Nursing*: "Psychology and Its Application to Teaching and Discipline," A. L. Suhrie, Ph.D.; "How Can Instructors Be Helped to Do Their Best Work?" Elizabeth Burgess.

tion; how can I with my experience and ability serve most effectively in this crisis that we as a nation are passing through? And I am convinced that we who are teachers of public health nurses can at least for the present serve best by training the greatest possible number of nurses for the work of health conservation. This is a teaching problem, clearly, because without students we cannot teach. I will try to show just why I consider public health nursing a patriotic service, just why it is a national need, and just why I feel that our greatest problem is to obtain greatly increased numbers of nurses for our training courses in New York, Philadelphia, Cleveland, Chicago, Boston, and elsewhere.

We have come a long way since the time when victory was believed to depend only on those actually fighting on the battle field. It seems incredible now that anyone ever believed it. It has become a commonplace that preparedness either for peace or for war depends equally on industrial organization and conservation of national resources. Of all our national resources, human life is the most important. Public Health Nursing directly contributes toward the conservation of human life; this is the fact that I want chiefly to emphasize today.

I should hardly be speaking as I do, if the public health nurse's work were merely bedside nursing, or if it concerned itself merely with the welfare of sick persons, fundamental and necessary as such service is. This she does and will continue to do; but her most important function is not the cure, but the prevention of sickness. Six years ago Dr. Winslow called the visiting nurse "the most important figure in the modern movement for the protection of public health;" and since then her field of usefulness and her usefulness in her field have enormously expanded. Her contribution to the public safety is her preventive work.

It is hard to show by figures and diagrams the value of any preventive work. No one can say just how many cases of malnutrition nurses prevented last year by teaching mothers how to feed their children, or how many cases of cardiac disease she prevented by keeping the child with scarlet fever from infecting his brothers and sisters. The nurse is not the only health agent at work, and we do not wish, even if we could, to give her glory beyond her due. Some results can be measured, however, and in order to illustrate the kind of preventive work done by public health nurses I should like to describe two studies recently published.

The first is a study by Mr Michael Davis of prenatal care given during the years 1914 and 1915 to 731 pregnant women in 5 wards of Boston. This care included work done by prenatal clinics and medical attendance at delivery, so that the nurse, though essential, was not the only factor. Her work consisted of visits at 10 day intervals, persuad-

ing the expectant mother to attend a prenatal clinic, instructing mothers as to hygiene of pregnancy and preparation for confinement, followed by nursing visits for about two weeks after delivery. Details of the experiment I will not go into; they are available in print. The important point is that the death rates among these babies where mothers had prenatal care were reduced from one-half to one-third of those found among babies not receiving prenatal care in these wards during the same period. This reduction held for the first week, first month and first year of life. Not less striking is the fact that the proportion of still births was only one-half that of the general population.

We must face the fact that at no distant day men of our nation may be called upon to die, fighting for their country on land or on the sea. Is it not then doubly worth while to save the lives of these babies? "The true victory," said General Baden-Powell, in the first annual report of the Canadian Patriotic Fund, "will lie not so much in the actual tactical gain on the battlefield today as in the quality of the men who have to carry on the work of the country after the war. War kills off the best of a nation's manhood; therefore, extra care must be exercised to save every child—not for its own sake or for its parents' sake but for the sake of the nation. It has got to be saved from infant mortality, then from ill health, and finally from drifting into being waste human material. We must economize our human material. Each individual must be made (1) healthy and strong, (2) endowed with character, for becoming a valuable citizen for the state."

The other illustration that I should like to give you shows some results of the visiting nurse service of the Metropolitan Life Insurance Company. This company has over 10,000,000 industrial policy holders, and the study applies to the diseases causing nearly half the white mortality in 1911. After allowance had been made for all other factors known to the statisticians, the reduction in death benefits due to the nursing service and public health education was 12.8 per cent. That means, of course, saving the lives of nearly 13 per cent of this vast number of people. Reduction in death rates always means reduction in sickness as well, so that improved health as well as the saving of life has been the result of the nursing service. Is not any saving of life, necessary as it is in time of peace, doubly necessary for a nation at war?

I hardly need to go back to the time when nurses began their work in public schools, and tell you how school nursing first made school medical inspection effective. Statistics are available to us all, showing results in remedying physical defects and controlling communicable diseases. I should like now to connect these well known facts in your minds with a statement I saw recently to the effect that in New York

City last summer 75 per cent of the men who applied to enlist in the National Guard for service on the Mexican Border were rejected by the recruiting officers for physical disability. A large number of these rejections were for heart lesions, kidney disease, and such disabilities as defective teeth, hearing and vision. If, as children, these men had received the treatment for their defective eyes and ears and teeth and tonsils that is given wherever effective health work is carried on in school, if the germs of scarlet fever and measles and diphtheria that impaired their kidneys and hearts and hearing had been destroyed before reaching them, we may safely say that not only the spirits but the bodies of many of these 75 per cent would have been fit for service. Surely it is a grave situation when three-quarters of a large body of young men are unfit for active service.

In Great Britain after two years of war, a Committee on Health of Munition Workers said:

At the present time, when war is destroying so much of its best manhood, the nation is under special obligation to secure that the rising generation grows up strong and hardy, both in body and character. It is necessary to guard not only against immediate breakdown, but also against the imposition of strains that may stunt future growth and development.

This is no time to turn our attention away from the health needs of children. It is a time rather to redouble our efforts to increase the number of school nurses and infant welfare nurses, until adequate provision has been made to meet the health needs of every child in every state of the Union.

If European experience during this war has shown one thing more clearly than another, it has shown the part played by organization for national defense of all forms of labor and technical skill. Not only those in the firing line are giving full measure of patriotic service, but equally those who are keeping alive the fundamental industries without which no army can continue the struggle, without which no modern nation can live.

Among the famous 100,000 that first went from England to the trenches in France were physicians, engineers, mechanics, and other skilled workers. The greater need of these men at home was demonstrated, in many cases too late. We have been warned to avoid such blunders. We shall doubtless make our own original blunders in our own original way; but specially trained workers should be very sure they are right before giving up necessary work that they and no others can do.

I should be sorry to give the impression that I consider Public Health Nursing the only way, or necessarily the best way, for a nurse to

serve, and I should be distressed to have any one think that I am urging against enrolling in the Red Cross, on whose National Committee on Nursing Service I have the honor to serve. This I am far from either thinking or doing. I do, however, think that young graduates, fresh from their surgical experience are at least as good and probably better for Red Cross work than public health nurses whose hospital experience is necessarily more remote. On the other hand, the only person who can fill the place of a specially trained public health nurse is another specially trained public health nurse. If the time comes when public health nurses are more needed in the Red Cross than in their own communities; I do not need to tell you where we shall all be found; but our duty seems clear as long as equally or better qualified nurses are available.

The full horror of war we cannot realize now and perhaps we never shall. Yet we cannot blind ourselves to the fact that the threatened food shortage alone is cause for grave anxiety. Mr. Hames Storrow, Chairman of Governor McCall's Committee on Public Safety, said recently:

"We are seeing the greatest dearth of food the world has ever seen. Moreover, though we ourselves need food we are in duty bound to supply it to the Allies with whom we have joined forces. We cannot sit at home feeding ourselves while they are out on the battlefield hungry." He predicted that the nation's grain crop will be 60 per cent below normal. "Half the poultry raised in Massachusetts," he continued, "is being killed because of the lack of grain, and farmers in New England are killing their cows. In consequence there will be shortage of eggs and milk."

We know only too well what actual shortage of food will mean to the poor. The high cost of food now is serious enough. Utilizing to the best advantage whatever food there is will become increasingly important. "Every housewife," said Mr. Wilson, in his proclamation of April 15, "who practises strict economy puts herself in the ranks of those who serve the nation." Teaching women in their homes how to feed their families is one of the duties of tuberculosis nurses, infant welfare nurses, school nurses and all other public health nurses. The less food there is, the more is such teaching needed. In the interest of national efficiency it must not be curtailed.

The supply of nurses with special training for public health work is now entirely inadequate; in the future the need will be greatly increased. This is true in all forms of social work. We shall have more undernourished children, more bottle-fed babies of mothers working away from home, more destitute families, more poverty, more sickness.

To meet this as far as nurses can, we shall need greatly increased numbers of women trained for such work. To obtain these students is the most important problem of public health instructors today, and I want to make the strongest appeal I can to the profession as a whole to help in supplying this need. I want especially to appeal to superintendents of training schools to bring it to the attention of their pupils. The expense of a postgraduate course is an obstacle; but the question now is not only whether we can afford to make ourselves as useful as possible to our country, but whether we can afford not to.

In closing I want to say that I wish President Wilson had included women in his plan for the selective draft. In Europe war has already shown the value of women's work for national defense. Very many women, I believe, would welcome an organization competent to direct them either to continue their regular work, or to assign them to other work where their particular experience and ability would ultimately be more effective. As no such demand has been made upon women, it remains for us, each for herself, to decide, soberly, unselfishly, patriotically, just where and how in the long run we can serve our country best. "The supreme test of the nation has come," said Mr. Wilson. "We must all speak, act, and serve together!"

#### A SERIES OF LECTURES ON PUBLIC HEALTH NURSING

By MARY BEARD

##### VI. HEALTH INSURANCE: AS CONSIDERED BY STAFF OF PUBLIC HEALTH NURSES

"You're lame," said the visiting nurse to Mr. C. "Yes, I've got rheumatism and it takes me pretty sharp sometimes. When my wife's well again I'll lay off and see a doctor." A little questioning brought out the fact that the rheumatism was quite bad enough to be attended to, but he could not be persuaded to lose work now just when they expected the new baby. Twelve dollars a week when it is not interrupted will go a good way towards food, rent, clothing and saving for the doctor when you know a doctor will be needed at a given time, but a good steady husband does not interrupt the income just at this time and he goes without what he cannot afford—or at least Mr. C. did.

And because he was steady and independent and proud enough to care for his family, trouble overtook him. The rheumatism did not wait until he could afford to "lay off" but became so acute he was forced to stop work. And the last state of that family was one of

dependence, with bills for the wife's confinement to be paid and a "chronic heart" for the man to carry through life.

Under a health insurance act, with a maternity benefit, his care for his wife would not have put it out of the question for him to see a doctor in time to prevent his own serious illness. Under a health insurance act he might have received a cash benefit after a few days illness, and he would have known that a doctor was available, and that he *had been already paid*, the patient himself sharing in the payment.

Against all this evil he would have been insured by the weekly deductions from his pay envelope of \$.18 or thereabouts.

Because this story is typical of many in our experience I use it to introduce the following studies which were made by the district nurses of Boston.

These present some evidence on three points:

I. Do people need Health Insurance?

II. Would the payments under a compulsory contributory system work a hardship in the family?

III. Are present health agencies sufficient or could they be extended to cover the need?

We believe in the contributory feature from the patient's standpoint. Many a time we have found a family in need of medical care with very little to spend and have sent in a good doctor who, in the kindness of his heart did not make any charge, only to be told on the next visit that the patient was pretty sick and they "had called in a *real doctor*," i.e. one who expected cash on delivery!

For thirty-one years there have been district nurses in Boston. To-day they go to any house and nurse for any practising doctor in town. Only diphtheria, scarlet fever and smallpox patients are refused. Last year we had 14,930 patients, made 145,000 visits and served in every ward in Boston. Ninety nurses are doing this work, of whom thirty are graduate nurses learning to do public health nursing.

These nurses do their nursing and return. They are not resident nurses. The cost of a visit is \$.55.

Sixty per cent of all patients are pay patients or part pay patients.

Forty per cent are free.

The families were studied in order to secure evidence of facts of which the nurses' experience made them very well aware.

I. How did the family income affect the calling or failure to call a doctor when he was needed?

II. How many patients were incapacitated by the illness which took the nurses into these homes? We hoped some light might be shed upon the question of income as related to medical care, for illness means

very often that the regular wage upon which the family is dependent is cut off just when unusual expenses of illness appear.

*Explanation of study*

Number of patients..... 1038

Income groups

I.....	Under \$12 weekly
II.....	\$12 to \$15 weekly
III.....	\$16 to \$20 weekly
IV.....	\$20 and over

Size of family

A.....	1 in family
B.....	2, 3 or 4 in family
C.....	5, 6 or 7 in family
D.....	8 or over

Table 1 divides these figures according to type of disease; incapacitating, non-incapacitating and a total of all diseases.

Table 2 shows the result in numbers separated into family groups.

On September 27 the nurses visited and knew with some degree of intimacy 1038 persons most of them living in a family.

In 37 per cent of these families the income was under.....	\$12
In 359 of these families the income was.....	\$12 to \$15
In 167 of these families the income was.....	\$16 to \$20
In 142 of these families the income was.....	\$20 or over

Ninety-eight had no medical care before we came. With many of those who had received such care at a hospital or dispensary the benefit to the patient was very slight because the visit had been casual and not followed up.

The study divides the patients as to medical care as follows: None, private doctor, hospital or dispensary. In most cases the lowest income group has least medical care, the percentage is 13 for the lowest income group and 7 for the highest. The percentage of families receiving private medical care is modified by the locality studied—where dispensaries and hospitals abound and are easily available they are more frequently used.

On October 15, 1916 another study was made by the Boston district nurses, this time in relation to weekly premium now being paid in the families under care on that day. All forms of insurance were taken, the object being to form some opinion of the present drain on family resources.

TABLE 1  
*A study of 1038 patients, concerning medical care  
 All diseases*

	TOTAL	NUMBER HAVING PRIVATE DOCTOR	PER CENT PRIVATE DOCTOR	NO PREVIOUS MEDICAL CARE	PER CENT
Group I.....	370	82	22	48	13
Group II.....	359	140	39	28	8
Group III.....	167	93	56	12	7
Group IV.....	142	109	77	10	7
Total.....	1,038	424	41	98	9½

*Incapacitating diseases only*

	NUMBER	PRIVATE DOCTOR	PER CENT
Group I.....	189	60	31
Group II.....	133	82	62
Group III.....	80	51	64
Group IV.....	81	71	88
Total.....	483	264	55

*Non-incapacitating diseases only*

	NUMBER	PRIVATE DOCTOR	PER CENT
Group I.....	181	22	12
Group II.....	226	58	26
Group III.....	87	42	48
Group IV.....	61	38	62
Total.....	555	160	29

Table 3 gives a part of the figures received by the study. It tells a part of the story. Money is now being paid to insure peace of mind to the wage earner. Most of the money which will be paid to the insured will be spent in funerals. In Massachusetts it is known that only between thirty and forty cents of every dollar spent for industrial insurance comes back to the insured person or his family in benefits; while in compulsory health insurance, as set forth in the Acts under consideration in many of our states, the direct and indirect benefits to the insured include benefit, cash, adequate medical services and nursing care, together with a small death benefit.

Professional nursing care paid for by the Metropolitan Life Insurance Company and available the moment the patient feels he needs it

TABLE 2

*Study of all patients under care on September 27, 1916  
Concerning medical care preceding first visit of nurse  
Incapacitating diseases, non-incapacitating diseases*

INCOME GROUP	SIZE OF FAMILY	NO. PREVIOUS MEDICAL	PREVIOUS MEDICAL BY PRIVATE DOCTOR	PREVIOUS MEDICAL IN DISPENSARY OR HOSPITAL	NO. PREVIOUS MEDICAL	PREVIOUS MEDICAL BY PRIVATE DOCTOR	PREVIOUS MEDICAL IN DISPENSARY OR HOSPITAL	TOTAL IN GROUPS
Group I, Under \$12. ....	A 49	6	9	18	3	5	8	49
	B 198	9	38	57	11	12	71	198
	C 103	3	12	28	11	4	45	103
	D 20	4	1	4	1	1	9	20
Total of Group I.....	370	22	60	107	26	22	133	370
Group II.....	A 8	0	1	2	1	2	2	8
	B 184	2	37	19	11	33	82	184
	C 125	4	35	15	7	18	46	125
	D 42	1	9	8	2	5	17	42
Total of Group II.....	359	7	82	44	21	58	147	359
Group III.....	A 4	0	1	0	0	1	2	4
	B 72	2	22	5	2	26	15	72
	C 56	3	21	9	2	10	11	56
	D 35	2	7	8	1	5	12	35
Total of Group III.....	167	7	51	22	5	42	40	167
Group IV.....	A 0	0	0	0	0	0	0	0
	B 60	0	34	0	1	22	3	60
	C 42	2	21	2	2	10	5	42
	D 40	0	16	6	5	6	7	40
Total of Group IV.....	142	2	71	8	8	38	15	142
Grand total. ....	1,038	38	264	181	60	160	335	1,038

is the secret of the fine results in preventive medicine secured by that company through its nursing service. Preventive merely because the paid professional service was at hand.

Public health nurses look forward to a time when legislation by securing a universal service of this sort will produce a democracy of health conditions worthy of the traditions of the United States concerning public education.

TABLE 3  
*Study of families under care October 15, 1916*  
*Concerning payments of weekly premium*

INCOME GROUPS	TOTAL NUMBER	NUMBER INSURED	PAYING WEEKLY PREMIUM					
			\$10-.25	\$25-.40	\$40-.75	\$75-\$1	\$1.-1.50	Over
Group I, weekly, income under \$12.....	325	192	59	49	52	16	12	4
Group II, \$12-15..	310	201	34	54	76	18	16	3
Group III, \$16-20.	153	121	19	12	42	21	21	6
Group IV.....	132	112	6	12	23	19	34	18
Total.....	920	626	118	127	193	74	83	31
		67.5%	12.7%	13.8%	21%	8%	9%	3.4%

No insurance, 294; 32.5 per cent

67.5 per cent of all families had some form of insurance

Only 8 per cent of all families had some sick benefit, the per cent increasing with income

59 per cent of Group I insured.

64 per cent of Group II insured.

78 per cent of Group III insured.

84 per cent of Group IV insured.

12 per cent of this insurance gives a weekly sick benefit for a limited time.

41 per cent pay over \$.40 per week.

55 per cent pay over \$.25 per week.

In 90 per cent of the 626 cases of insured persons, the payments are over 1 per cent of wages.

In 60 per cent the payments are 2 per cent of wages or more.

#### NOTE

At the request of Miss Beard, we publish the following letter addressed to her by Dr. D. B. Lowe, of the B. F. Goodrich Company, of Akron, Ohio:

May 3, 1917.

Miss Mary Beard, Director,  
 Instructive District Nursing Association.  
 Boston, Mass.

MY DEAR MISS BEARD:

I am greatly interested in your article on "Public Health Nursing and Its Administration" which appears in the PUBLIC HEALTH NURSE QUARTERLY for April, 1917, on page 147.

I am still more interested in the paragraph which begins in the middle of the seventh line from the bottom on page 150 in reference to a nurse being in charge of our Health Department and having under her direction thirty-nine nurses and four doctors.

May I ask where you obtained this information, which is absolutely incorrect and which should never have been used in the manner in which it was? It leads to false impressions and certainly such a statement should have been verified before being made public as a fact.

I may state that the personnel of this department consists of a director, a staff of eight full-time physicians, two full-time dentists, two part-time physicians, two part-time surgeons and twenty-five nurses. The nurses are under the direction of Miss Eugelia Eddy, who has the title of "Supervising Nurse."

It would give me great pleasure to see this error corrected in a subsequent issue of the *QUARTERLY*.

Very truly yours,

D. B. LOWE, M.D.

*Director, Department of Health, the B. F. Goodrich Company.*

### THE VALUE OF OCCUPATIONAL THERAPY IN CARING FOR CHRONIC PATIENTS

By A. M. CARR

The formation of state societies, focussing the awakened public interest in mental hygiene, has very naturally roused public interest in the methods employed to maintain or restore mental health.

It is now generally conceded that "occupation," with all that term now embraces of the many and varied forms of arts and crafts, of diversional employment, of exercise and recreation, is one of the most effective curative measures at our disposal. Considering the importance now attached to the whole question of physical and mental re-education the writer feels that public health nurses as a whole are not entirely alive to the therapeutic value of carefully considered occupation.

All district nursing associations, all rural nurses, in fact all public health nurses, are constantly confronted with the difficult and usually pathetic problem of the chronic invalid and the knowledge that though the hour or so of daily, or more occasional, nursing care is of inestimable value and comfort, the many hours in between are too often of a length and weariness difficult to realize by those whose days are filled with the priceless boon of productive work.

Dr. Richard Cabot has exhorted us to remember that in all chronic cases there is inevitably a mental element, which must be recognized in the summing up of essential treatment. It is this mental element, and the therapeutic measures at our command, that is too frequently unrecognized or neglected in the otherwise conscientious nursing care given to our chronic patients.

There are reasons for this oversight. In the first place it is only recently, even in the field of mental hygiene, that occupational therapy

or the newer and more comprehensive term, "ergo-therapy" (work-therapy) has been given its full significance in the scheme of treatment. In the second place, up to the present time the crowded curriculum of the training school of the general hospital has found it difficult, if not impossible, to include even the most elementary instruction in this branch of therapy. Few nurses outside those who have graduated from mental hospitals, or who have taken post-graduate courses, have any definite knowledge of the principles and methods of occupation considered in the light of a curative or alleviative measure.

It would not be possible in a short paper to take up the forms of occupation—nor necessary. Admirable books can be obtained for study. It is only with the hope of creating more general interest in the subject that the writer ventures to put forth a few suggestions.

If nurses would realize that simple varieties of easily acquired occupation are actually remedial measures, to be carried about as faithfully as a clinical thermometer or disinfectant tablets, they could in many instances change a life which is merely a dreary existence into one in which the quickening joy of achievement brings new hope and energy. If this form of therapy were applied with the same degree of intelligence and skill we put into massaging a stiffened joint, or adjusting the position of a crippled body, even more satisfactory results could be obtained. We talk much in these days of "self expression." Deep in the humblest heart, in the most physically oppressed existence, that ineradicable instinct persists, and its cultivation in the repressed or handicapped is worthy of the exercise of the most delicate art.

The increased interest of the patient to the nurse—as a "case" and as a personality—is amazing where even the simplest varieties of occupational therapy are skillfully used. The monotony of the nursing care is greatly lightened. There is a definite and absorbing subject on which to converse, progress to be noted; one interest or piece of work often leads to another, and members of the family will perhaps become as pleasantly involved as the patient.

The responsibilities, cares and accompanying fatigue of the life of a visiting nurse sometimes tend to obscure her perception of the importance of less material things. The value of even a moderate amount of happiness is incalculable, while simple gaiety in these stressful days is a gift of the gods. The starved imagination that may find wings in knitting a bright scarf with even the slowest fingers, with the added realization of its later *use*, is worth encouraging, while the actual curative and strengthening effects of the exercise and the concentration of the patient's mind on a manual occupation will be very noticeable. The signal success that has followed the efforts made in Europe and in

Canada for re-education of crippled soldiers has greatly stimulated public interest in applied occupational methods.

Very recently there has been organized in this country a National Society for the Promotion of Occupational Therapy, with Mr. George E. Barton of Consolation House, Clifton Springs, N. Y. as President. Miss Susan E. Tracy, Mr. T. B. Kidner, Vocational Secretary of the Canadian Military Hospitals Commission, and other well known men and women in the widening field of mental hygiene are members of this interesting new society. Its object is to provide information and assistance to all who desire to teach the work or who are interested in it.

The suggestions the writer ventures to make are:

Talks at meetings of an association on the new aspects of occupational therapy—or ergo-therapy.

Some outline of instruction for visiting nurses in simple forms of occupation, recreation and exercise. Incidentally this might be of value in encouraging that excellent antidote to a too serious life, the getting of a hobby.

Follow-up work, which can often be admirably done by members of auxiliary committees.

Visits to institutions where work and recreation are organized as occupation, and where results can be observed.

Purchase of books to encourage study of the subject.

The following books are suggested:

*Studies in Invalid Occupation*, Susan E. Tracy, (Whitcomb and Barrows); *Occupation for Nurses*, Dr. W. R. Dunton, (W. B. Saunders and Company); *The Work of our Hands*, Herbert J. Hall; *Occupational Therapy*, George E. Barton, (Lakeside Publishing Company).

Magazines. *Industrial Arts Magazine*; *Something To Do*; *Craftsman*.

Lists of simple books on various handicrafts can easily be obtained.

## THE BACKGROUNDS OF OUR IMMIGRANTS

### II. THE PORTUGUESE OF PROVIDENCE, RHODE ISLAND

#### INTRODUCTION: THE BACKGROUND

##### PART I

Portugal is one of the most picturesque countries of Europe; it is a country of extremes, also, and even in Lisbon one of the finest electric car services in the world (installed a number of years ago by an American firm) may be found side by side with the oxen of the Orient.

Always taking into consideration the fact that time does not enter into his calculations, the Portuguese peasant is industrious and often

strives very painstakingly to cultivate his *quinta*, or market garden. Lack of water is the greatest drawback to the agricultural prosperity of the country, and unhappily for many years past the ruthless cutting down of timber has lead to a decrease in the rainfall. Laudable efforts at irrigation are made by some of the more intelligent peasants, and the sight and sound of the oxen slowly driving round the *nora*, or well, is the usual accompaniment of a summer's day. It is customary to blind-fold the oxen while they are engaged in this task, and sometimes they are left to work alone, while the owner is engaged in another part of the *quinta*, the melancholy creaking of the machinery serving not only to show that the patient workers are performing their task, but also as a charm to drive away evil spirits.

The scenes in the Portuguese villages are often quite Biblical in character—indeed, it has been said that if Adam could come to life again at the present day the only European country in which he would find scenes to recognize would be Portugal. The oxen may be found treading out the corn, or men may be seen thrashing it with flails, and sometimes a group of children is found husking it by hand. Wooden ploughs are used; and the ox wagons in country districts are sometimes solid blocks of wood, roughly rounded, and with a hole in the middle for the axle.

The Portuguese are an artistic and a musical people; the quaint national airs known as "Fados" are to be heard everywhere; and some of the churches and monasteries, such as those of Batalha, or Belem in Lisbon, are world famous for their architectural beauty. Even in more every day matters this artistic sense is strikingly apparent; many of the footwalks in Lisbon are paved in the most accurate and pleasing patterns, which have taken years to complete; the outside of the wealthier homes are often beautifully tiled, and in many squalid little houses may be found an inset in white and blue tile, usually bearing the representation of some saint or holy scene; these tile pictures are very curious and sometimes very old, occasionally bearing a date some fifty or sixty years back—the art is now, unfortunately, being lost, for the modern tiles do not keep their color as do the old ones. The peasant dress is very picturesque; brilliant colors are worn by men and women alike, the former being particularly fond of the magenta sash, while the latter invariably wear a bright hued handkerchief on the head; the self-respecting Portuguese peasant woman will not be seen out of doors in a hat, nor with her head uncovered. It is also noticeable that one hardly ever sees a Portuguese peasant, however poor, with holes in his or her clothes—they may be patched beyond hope of recognizing the original theme, but holes there will be none. Many of the women, particularly those of the North, wear a large amount of jewelry—particularly enor-

mous earrings, for this is the form in which they carry their wealth: this jewelry is always real. In the stores of Lisbon or Oporto many very beautiful pieces of jewelry may be found, and the Portuguese are very clever in the art of filigree work.

The fountains are always centers of interest, both in town and country, and many are the pictures worthy of an artist which are to be found in the grouping of women and children carrying on their heads the quaint *bilhas*, or water bottles. Every little dirty streamlet is utilized for laundry purposes, and the most extraordinarily white clothes are produced from the most painfully dirty looking water, thanks to the bleaching qualities of a southern sun.

The fame of the Portuguese sailors, from Vasco da Gama and Henry the Navigator downwards, is world-wide. Very curious are some of the craft to be found on the rivers and bays of Portugal, whether it be the wine boat of the Douro, with its long, unwieldy rudder, or the smacks of the sardine fishers of Setubal. The bay of Setubal, with its blue waters rivalling those of Naples, and its little unexpected coves, and the river bordered with graceful eucalyptus trees, which runs into it, is very wonderful; and sloping down to the outer bay is the emerald green of the Serra da Arrabida, dotted, from the shore upwards, with numerous shrines in honor of Our Lady of the Arrabida. The village itself is devoted to the sardine industry and the quay is lined with "factories" in which the fish are cleaned, tinned and packed by deft-handed girls.

Schools are few and far between, and but a small proportion of the Portuguese ever learn to read or write. Women and girls are expected to do much of the hard work, and they may often be seen walking in front of the oxen with the goad, while the men peacefully sleep inside the wagon.

The peasants live often in the greatest poverty; but the bright sunshine and outdoor life mitigate somewhat evils which, in a less friendly climate, would have disastrous results. If, however, we find that the Portuguese immigrant has but vague or non-existent ideas of hygiene and sanitation, we can always remember that no one, in his own sunny land, has thought to teach him better.

## PART II

### THE PORTUGUESE IN PROVIDENCE

By ANNE G. VERNON

Portuguese immigration was almost unknown in this country until after the Civil War, but in the late sixties we find the Portuguese making



TREADING OUT THE CORN IN THE OLD COUNTRY



RETURNED TO THE LAND IN THE NEW COUNTRY



THE LAUNDRY OF THE OLD COUNTRY



THE SARDINE FISHERMEN FROM WHOM COME FISHING AND OYSTER  
WORKERS OF PROVIDENCE

their way in fishing or whaling vessels to the shores of the New England coast. Here they could follow their native callings as fishermen, long-shoremen, and stevedores. They have come in increasing numbers until in 1915 there were 5780, which was the time the last census was taken; there are of course many more now than there were then.

The earliest settlements of the Portuguese were in New Bedford, but they soon crossed the boundary line between Massachusetts and Rhode Island and found their way into the fishing and oyster industries of Providence. As with other aliens, the men of the families came over first to establish themselves and earn money enough to enable them to send for their women and children. If savings were not sufficient and they had no property in the old country on which to realize money, the steamship company always stood ready to make a loan. Such a debt has handicapped many a family for months after their arrival, women and children often denying themselves necessary food and clothing in order to repay the sum borrowed.

This custom of the men coming first, which is often economically advantageous, is morally most disastrous, particularly among the Bravas whose moral standards are often very low.

In Providence there is a great lack of decent lodging or boarding houses for the men, which lack has resulted not only in bad overcrowding of these places, but in the ever-present lodger found in great numbers in the tenement homes. Portuguese women find it hard to resist the opportunity to eke out the husband's insufficient income in this way, although it may mean many hours of hard work for little pay.

One dollar a week pays not only for the bed and lodging but for the preparation of the man's meal, for which he provides the food, and also for the washing and ironing of his clothes!

In Providence are two distinct types of Portuguese: those who come from the continent, the Azores and Madeira, and those who come from the Cape Verde Islands. These latter, or Bravas as they are known here, are largely of African stock, though having lived under the Portuguese flag, they speak that language, using a patois which is quite different from the dialect of the other Islanders and Continental Portuguese. As do other foreigners, the Portuguese tend to congregate in certain sections of the city. The Bravas, who are looked down upon by the others as an inferior race, have settled in the poorest sections near the docks, along the Providence River; the Azoreans, who comprise the larger part of the remainder, along the Seekonk River. These latter are rapidly moving into the better parts of the city.

The social customs of the people are extremely interesting, many of them being very charming. Indeed, America has much to learn from them, as for instance in their observance of the Christmas season.

In place of our laden trees and materialistic Santa Claus we find family altars erected to the Christ Child. The home, no matter how small and meager, is swept and garnished, windows shining and curtains spotless and then in the *best* room, be it parlor or chamber, according to the means, is placed the altar. About the statue of the Virgin Mary and the infant Jesus are arranged vases of paper flowers of gorgeous colors, and vessels of all shapes contain the growing hemp and wheat, the seeds of which were sent from "home." Then, on Christmas eve and for eight nights following, lighted candles proclaim the Christ Child's birth.

Where can one find a sweeter custom than that of the Portuguese mother, who on the death of a baby, chooses some child less fortunate than her own, and dresses it in memory of the little one she has lost?

Few godparents in America live up to their responsibilities as do the Portuguese. Whenever children through sickness, misfortune or death are deprived of parental care, there you will see the godparent fulfilling his responsibility, whether it be the paying of a christening or a burial fee, or the sharing of his home until the boy or girl can become self-supporting. Expressions of surprise bring forth the response, "He is my godchild. What would you have me do?"

It is unfortunate that the patriarchal life of the Portuguese as it exists in their own country, where the word of the head of the family is law, receives many a blow in this land of liberty. The freedom given boys and girls in this country seems to their parents unprecedented license and the young people are often unfairly and harshly judged by their elders.

In contrast to these beautiful customs are the superstitions which still exist among them, many of them fatalistic in tendency. Surgical or medical care is often refused, not alone through fear or ignorance, but through the belief that what is sent by God and is His will should not be tampered with by man. Today in hidden corners can still be seen the practice of witchcraft and incantations as a cure for mental ills. Through education these superstitions are slowly but surely being overcome; the district nurses are the best of teachers and the increased attendances at the baby clinic show the mother's growing willingness to learn.

Mortality among the Portuguese is higher than with any other race. This is due partly to ignorance and superstition and partly to the fact that, having come from a warm country, they are unable to face the cold of our rigorous New England climate.

The adult Portuguese miss the outdoor life of the Azorean isles and, being peculiarly sensitive to the cold, the natural result is closed windows and overheated kitchens, followed by grippe, bronchitis, pneumonia,



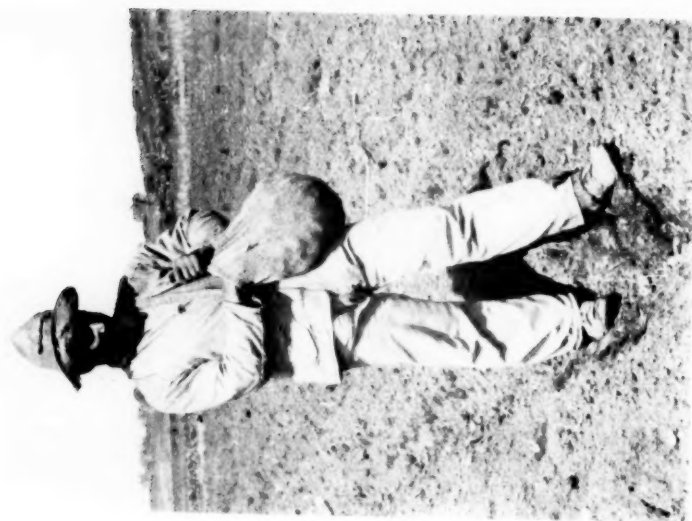
A PLAYGROUND IN PORTUGAL



A PLAYGROUND IN PROVIDENCE



A PORTUGUESE PEASANT



A PORTUGUESE PEASANT IN PROVIDENCE  
(Photo by F. W. Marshall, Providence Journal.)

tuberculosis, and many pathetic little widows who are totally unfit physically and mentally to cope with the economic problem of caring for the home and children and at the same time working for their support. Can the bitter cold of our climate be held accountable for the seasonal desertions of recreant husbands who migrate to their sunny islands in the fall and return to America in the spring?

As a race the Portuguese are sober, industrious, thrifty and law-abiding. In 1916, out of twelve hundred arrests for drunkenness in the city of Providence, only seventy were Portuguese, while the police testify that, as a whole, they give less trouble than any other nationality.

Love of music, color and nature finds expression in nearly every home. Growing slips and blooming plants fill the sunny windows during the cold months, and the ash heaps of the winter blossom into gardens in the spring. A spray of sweet geranium or a bunch of posies is their gracious way of showing gratitude for some service rendered.

Generous to a degree in helping their own, a needy fellow countryman is never turned away, rather given a warm welcome, a bed and a share of the humble fare until work or a home is found. When thrifty, the Portuguese accumulate savings very rapidly, for they are willing to be extremely frugal if the object to be attained is worth the sacrifice. Seven years in the country and Tony Oliveira is the proud possessor of a home and a motorcycle, the latter costing four hundred and fifty dollars, cash down. This is not an isolated case by any means.

Love of country and outdoor life, farming and chicken raising is inherent in all Portuguese and the first savings are always invested in a plot of land which can be cultivated. After a few years the four to six tenement house of the city is vacated for the one family home which is their own. The Bravas have won for themselves the unenviable reputation for filthy yards and homes, but given a fair chance with decent tenements in decent localities they prove to be as good housekeepers as the best; this fact has been demonstrated in a group of houses remodelled for the Bravas by the Tenement Improvement Association.

The unskilled Portuguese work largely in the coal yards, on the docks as freight handlers or as oyster openers. Such work is largely seasonal and hourly. It commands large pay but seldom yields a full day's or week's wages, and as a rule wholly unfits the men for steady work at average pay. It also allows too much time for loafing about the kitchens, the pool or bar room.

The Brava women work in a few of the smaller factories and at domestic service, but can seldom learn a trade as few of the larger factories or jewelry shops are willing to employ colored workers.

The Azorean girls and women are rarely found in domestic service. They make lace in their homes or seek employment in the shops or factories where they are as welcome as the average American or Irish.

The Azoreans, unlike the Bravas, are working their way into the skilled trades as carpenters, masons, machinists and jewellers; many are going into business for themselves as druggists, grocers, merchants. These shops are largely patronized by members of their own races. Buying on credit is universal and this poor custom often results in debts so large that bankruptcy for the family or the grocer is often the only outcome.

In Providence, working papers, conditional on a rudimentary education and the previous securing of a job, are given to boys and girls alike, at the age of fourteen. The large families, the high cost of living and the tendency of the fathers to let their children support them combine to force the Portuguese boys and girls into industry at the earliest possible moment. The result is that few of them complete the grammar school course. Those who do graduate from the grammar school are apt to continue through high school and a few ambitious ones enter Brown University. It is interesting to find that even in the legal and medical professions, the Portuguese have their representatives.

Night schools for men and women, with classes in simple English branches, are open six months in the year. Here boys and girls who are eager to study can secure grammar school diplomas. That the children are quick to seize and appreciate opportunities for learning is proved by their faithful attendance at a library which has been started for them in the Portuguese district.

Few of the Portuguese become naturalized and for this reason the Young Men's Christian Associations have started classes in citizenship and so we hope that the future will tell a different story. Comparatively little is being done in the industrial training or to give the right kind of recreational advantages to the Azoreans. However, the men and boys have several clubs of their own, among them a dramatic club. The latter has presented several plays, very creditably, in the Portuguese language.

The Bravas attend mission services held by the Central Congregational Church, which besides is doing a valuable work among them through English gymnasium and industrial classes, but the Azoreans are nearly all Roman Catholics. They have built a beautiful church of their own; the priests in charge are all Portuguese, though unfortunately they take little or no interest in constructive work with their own people.

Several benefit societies have been founded and run successfully by the Portuguese for the Portuguese. The largest society for men has a membership of three hundred and fifty, while the St. Cecilia Society for women has a membership of four hundred and fifty. Within the last eighteen months the Bravas, under the leadership of the assistant pastor of the Central Congregational Church, has formed a society for the Bravas only. They now boast that their number has reached the one hundred and fifty mark.

Since 1911 Providence has been a port of entry for the Fabre Line. The Portuguese immigrant is welcomed and protected through various agencies, among others the Young Men's Christian Association and the Immigration Bureau. Interpreters are always at hand on the docks and straighten out difficulties for those whose relatives have not materialized and to start aright those bound for other cities, and box lunches and hot coffee at cost contribute to the bodily comfort of the bewildered aliens. This work has been carried on and paid for by outside charitable organizations, but recently the Portuguese themselves have begun a like work, to supplement that already undertaken.

It is not enough to welcome and protect the immigrant when he first arrives: we must do far more if he is to become not only economically self-supporting but is to add to the moral and physical fibre of our nation. Through our schools we must give him better opportunities for learning English in preparation for citizenship; through industrial and manual training fit him for earning a larger wage, and through better housing and greater recreational advantages overcome his moral weaknesses. If between the Portuguese and the American there is a mutual giving and receiving of the best which each has to offer, there is every reason to believe that the Portuguese will become a real and valuable asset to this nation.

#### THE MEDICAL MISSIONARY IN INDIA

[EDITOR'S NOTE.—Miss Adelaide Woodard, M.D., of Seattle, Washington, was appointed a missionary of the Presbyterian Church, U. S. A., and assigned to India in 1914. From her station at Fatehgarh in the United Provinces, she sends the following interesting account of her year's work. Through a generous gift to the Board, there is now a possibility of two strongly equipped hospitals at this station, one for men and one for women, the idea being to have a strong central plant with medical out-stations in the form of district dispensaries through the area of the recent Mass Movement, where there are more than 20,000 Christians. We are indebted to the Board of Foreign Missions of the Presbyterian Church for the following account from Dr. Woodard.]

I cannot tell of souls saved or report great numbers who have turned from a life of darkness and sin to walk in the light of Christ. But I

can tell of the blind who have received their sight, the lame who have been made whole, the sick who have been healed. And I know that I have been doing the Master's bidding.

It has been somewhat of an effort to live up to the standard set by my predecessor Dr. Fullerton. There is seldom a day that I am not told by some grateful patient how "Dr. Fruton Miss Sahiba" did this or that and how she saved their babies, eased their pains and comforted the sorrowing ones. Besides this she left a nice dispensary building well supplied with instruments and appliances for the work, so that when I came I had only to begin.

Miss Mc Robbie<sup>1</sup> and Miss Jankinath had been doing good work for a year and preparing the way for the new doctor, so that many were waiting and they told others, and we were busy from the first. We had three beds; these were used, and we thought we were crowded; but before Christmas we had seven more cots. These we had out in the sun by day and on the verandahs at night. In January a good friend gave me a hundred rupees; with these I had six tents made and sixteen more cots. We had patients everywhere, in the waiting room and the two small rooms. During February, March and April we had between 20 and 25 patients most of the time, these with their families and friends filled the compound and road-side to overflowing.

Miss Mc Robbie went to Quaimgunj in November, and opened a branch dispensary. Miss Jankinath, the compounder, and I got on alone for a time, then Amy came. She is a young girl who is learning and is a great help. Later I got Hashmat, a trained nurse from Fatehpur, and thought we had quite a staff,—a compounder, a nurse and a probationer. For all ordinary work and some major operations we managed alone; but if possible when I had an operation that at home would require three surgeons, one interne and six nurses, I called in some one else, usually Mrs. Bandy (a missionary) to help. The little operating room that was used for dressings, examinations and everything else, had to be cleaned, disinfected and made as aseptic as possible. The operation completed, the patient was put out in the air to recover on the verandah or under the trees. Thanks to our well ventilated wards, and the blessed sunshine, we have had wonderful recoveries, patients going away rejoicing, showing their scars to their friends and telling them what had been done for them by the Isai Log (The Christian people).

One day I was called to the Gold Smith's alley to see a sick man. When I arrived there were a dozen sick people waiting to see the Dr.

<sup>1</sup> Miss McRobbie is a trained nurse whom the Board appointed in 1913.

Miss Sahiba. From them we were called from house to house. The first day I saw and prescribed for 30 patients. The next day we went to the Mohammedans, then to the Sadh and to Christian villages, and many other places, always with the same results, the people taking us from house to house, sometimes over the roofs or through upper rooms and passages and sometimes through dark gullies, but always to some ailing one either too sick or too afraid to come. Often we can do all that is required in the house, sometimes they come to us, and sometimes we just put them into the trap and take them out of the dark and the dirt to our nice, airy wards under the trees.

When Miss Mc Robbie has more bad cases than she could manage I have gone out to her. We have had some interesting times. One afternoon we called at a very wealthy high-caste Hindu house, where a poor, spoiled little purdah lady thought she was very ill. She had so many attendants and so much done for her that she could hardly appreciate our efforts to help her. From there we drove in an *ekha* to Raipur, where there was a poor old Mohammedan woman with a dislocated hip. Three weeks before she had fallen while drawing water from the well, had been helpless and in great pain ever since. There were no attendants or servants here, only a poor, dirty old woman lying on a filthy cot with swarms of flies over her. We cleaned her up a bit, gave her some chloroform and with much difficulty reduced the dislocation. I wanted to take her to the dispensary, but she refused to go as there was no one to leave at home and no one to go with her, so we had to leave her, trusting that she would soon grow strong and well.

The children followed us till the Pied Piper of Hamelin wasn't in it, and the people crowded around bringing their sick and leading the blind. One woman came with her mother on her back, a little old woman just skin and bones, bent almost double, wanting to be made strong and straight again. Many were helped and some came to the hospital later for operations and treatment. In one afternoon we saw and prescribed for over 60 people and during the year we had several such days.

We could not use the tents during the rainy season, and so had every foot of room in the verandahs of the dispensary and our own verandahs full of patients; but when we are so crowded and cramped for room we just look across the field to where the new hospital is being erected and think how glad we shall be to see it finished. We hope to have a class for nurses and compounders as soon as we have room. There are a number of applicants waiting now. There is no limit to the work to be done and I have visions of hospital work in Fatehgarh that will be second to none in India.

During the year 1916 we have seen at the dispensary 4,658 individual cases, and have treated over 16,000 persons, have made 1,680 calls in city and villages, had 306 patients to stay at the dispensary, performed 89 major operations, and 148 minor operations,—not counting boils, abscesses and slight injuries,—have extracted six cataracts and had 26 other operations on the eye. Have also dealt with many cases of pneumonia, fever and tuberculosis.

*Note*—Mrs. Bandy, of whom Dr. Woodard speaks as helping her in her operative work, gives the following account of one day in Dr. Woodard's busy life—

Dr. Woodard has more work than any one person can long stand up to. Every day a big clinic and some operations. One day I recall—she had about 75 at morning clinic before a 10.30 breakfast. After breakfast sterilized the little operating room and instruments and performed two abdominal operations requiring about four hours. After lunch she went to the city, where another clinic of 25 received attention and in one zenana she operated for an abscess. From there she was called to see a man in distress, and in a battle with death did an emergency operation. She came home for a late dinner which she could not eat. Had chills the first part of the night and fever after, but was up the next morning to the clinic.

### A SERIES OF LECTURES ON PUBLIC HEALTH NURSING, FOR STUDENT NURSES

By CECILIA A. EVANS

#### III. SPECIALIZED FORMS OF PUBLIC HEALTH NURSING

The specialized forms of public health nursing are industrial, tuberculosis, infant welfare, school, hospital social service, contagious disease and mental hygiene nursing. Rural nursing is sometimes referred to as belonging to this group, but it does not, because the nurse in a rural community finds that she must do any one or all kinds of nursing, as the needs may indicate.

The oldest form of specialized public health nursing is industrial nursing, which began to develop as early as 1897 when the Wanamaker Store in New York engaged a nurse to care for its employees. It was not until ten years later, however, that industrial nursing became widespread. Special nurses for the home care of tuberculosis patients were appointed about 1903 and shortly after this followed the appointment of special staffs of nurses for infant welfare, school and other forms of public health nursing.

These special forms of nursing started usually with the aid of private funds and for the most part were branches of a visiting nurse association. They grew out of a district need to attract the attention of the community to serious health problems, such as that of tuberculosis, infant mortality, and defects and communicable diseases among school children. The general population, which, at best, is more or less indifferent to the health of its members became interested in these special campaigns for reduction of morbidity and mortality, to a degree which it possibly could not have become through any general appeal to lessen either. Special nursing bureaus were, in the majority of cases, as has been said, branches of a visiting nurse association and were supported by private funds. In time these special bureaus separated entirely from the parent association, but still were supported by private funds subscribed by friends of this or that special nursing project. Following this, responsibility which heretofore had been assumed by small interested groups, was now assumed by the municipality, as it should rightfully be. Even then, however, these bureaus were kept separate under municipal control, as they had been under private supervision. In Cleveland, for instance, when the Division of Health established a Tuberculosis Bureau in 1910 and a Child Hygiene Bureau in 1911, the two bureaus were directed by different heads, with a special staff of nurses for each. School nursing, which was municipalized about 1909, was placed under the control of the Board of Education.

In all cities where public health nursing is highly specialized there is a separate staff of nurses for each bureau. This means that nurses from different organizations, either private or public as the case may be, visit in the same home in the interest of the various members of the family. It is a much mooted question whether this system or that of one nurse to the home is the better, and there is much that can be said in favor of both.

Tuberculosis, about which there has been so much publicity, began to receive attention as early as 1885, when Dr. Trudeau built a sanatorium for tuberculosis patients at Saranac, N. Y. The next step was the organization of an anti-tuberculosis league in 1892, and of the National Association for the Study and Prevention of Tuberculosis in 1905.

In each locality where the disease was widespread enough to attract attention, the appointment of a nurse to visit in their homes, cases that came to the general dispensaries was practically the first thing done. Later came the establishment of tuberculosis dispensaries.

The work of the nurses in this field consists of visiting the patients in their homes, giving advice as to diet, rest, fresh air and how not to expose others needlessly to the disease. Bedside care is given in some

cases, but for the most part, as the work becomes municipalized, bedside care is turned over to a private organization, and the municipal nurse confines her services principally to that of instruction.

Provision is being made more and more for institutional care for the incipient as well as for the advanced cases, and the best medical authorities are now urging such care for as many as can be accommodated.

There are many difficulties in the daily rounds of this work, for not only must the nurse have in mind the welfare of the patient, but that of his family and the community as well. The patient is frequently selfish and may be ignorant of the danger of spreading the disease, and often there seems little that can be done to save him or to protect those about him. On the other hand, the problem is complicated from without by hazardous employment, long hours, low wages, bad housing and the liquor evil.

While the death rate from this disease in the United States has been reduced from 203 to 147 per 100,000 of the population in fourteen years, it is still claiming more deaths than any other disease, with the exception of organic heart trouble, and will require our best efforts for years to come.

The problems of infant mortality began to dawn upon the community about the time tuberculosis did, and there seemed to be a growing alarm because of the high death rate among babies, especially in hot weather. Reasons of one sort or another were given, but for the most part it was generally thought that unclean milk was the main cause. To combat this problem, milk stations were established where mothers could go for good milk. About the same time a second cause of the high death rate was found to be ignorance on the part of the mother, who was found rearing her baby with practically nothing to guide her but tradition, superstition, and a maternal instinct which after all has its limitations. The solution determined upon was baby clinics with nurses to visit in the homes, giving advice and instruction to the mother in the care of the baby.

The infant welfare nurse, like the tuberculosis nurse, gets the best work done through her visits to the homes. It is through them that she finds the opportunity to demonstrate how to care for the baby by bathing it and dressing it, by modifying the milk if the baby is bottle-fed, and by inquiring kindly about family affairs, if there seems to be indication of trouble of one sort or another which may, sooner or later, affect the baby's welfare. She is the interpreter always of the doctor's orders and is instrumental in keeping the baby in attendance at the clinics. One of the best features of this work is the emphasis placed on keeping a well baby well. In many cities the municipality

is now supporting well baby or prophylactic clinics at convenient points for this purpose.

Baby work is in every way more cheerful than tuberculosis work, but it, too, has its discouraging aspects in the form of indifference, ignorance, selfishness, and neglect on the part of some parents. However, outside influences, as in tuberculosis work, play an important part in infant mortality. It has been shown by surveys made by the Federal Children's Bureau that babies suffer and die in direct proportion to insufficient family incomes, crowding, lack of good air, pure milk, pure water, and clean surroundings.

School nursing began in New York about 1902 and was an attempt made to reduce the number of exclusions from school because of ailments that could as well be cared for in the schools. The school nurse no doubt has a greater opportunity to influence the health standards of the coming generations than any other nurse. Her work consists of treating minor ailments at the school dispensary, and making room to room inspections weekly to discover children that should be excluded. She also gives health talks and drills to all grades. In addition she assists the doctor in giving each child a complete physical examination once a year and records the defects found. This part of the work is followed by recommendations to the parents for corrections to be made. Convincing parents of the need to have physical defects corrected is accomplished for the most part by visiting in the home. In view of the fact that children must go to school, and since the doctor and the nurse are now quite as necessary to a well equipped school as the teachers, we have every reason to believe that the present as well as the future generations will be healthier and stronger than they could possibly be without medical inspection and instruction.

Hospital Social Service has a different meaning in different hospitals, but it is generally understood to be the work which a nurse can do to lessen the recurrence of preventable diseases. Frequently a hospital enters a patient, cares well for him, cures him of the ailment and sends him home. In a short time, he may return with the same trouble, if not with a complication. This recurrence is often due to the fact that the hospital did not concern itself with home or working conditions and that the patient was sent back home to become "re-sickened." Hospitals today that take no interest in their patients outside of administering pills and potions become "repair shops" merely. Institutional treatment is too expensive to permit of needless readmissions and, aside from the economic questions which affect the patient, his family and even the community, there is the suffering to be reckoned with.

And as in the other special forms of nursing referred to, the nurse is in a position to assist both the patient and the hospital. To the one, she interprets instructions and treatments, while to the other she interprets facts which heretofore have been unrelated to either the patient's physical or mental condition.

Industrial nursing, like hospital social service, means something different in the different industrial plants. There is usually a dispensary in connection with the plant, where the employees may consult the nurse. She seldom works without a doctor's advice or standing orders. Besides binding up wounds and giving such first aid as is within her province, she visits in the homes when employees are recovering from a jollification or when they may be absent because of illness in the family. Home visiting provides the opportunity to clear up misunderstandings and often finds the explanation for a man's being absent-minded at his work or for watching the clock for the hour to leave. A sick baby, an invalid wife, or a delinquent child furnish sufficient reason for either.

While, formerly, industrial nursing was regarded as a philanthropy, it is now regarded as good business to protect the lives and health of the workers. What is more, the general public is awake at last to the dangers of industry and are not only recognizing, but demanding good working conditions.

Rural nursing marks the establishment of a piece of work long needed in the rural places. It necessitates that the nurse be broadly trained so as to find and to care for the needs of the home. She must care for all kinds of cases and is often the only person in the community to advise about material as well as medical relief. She frequently works under difficulties with respect to long distances, poor modes of travel, and lack of physical conveniences which the urban nurses have at their disposal. Her compensation consists not so much in a remunerative salary as it does in appreciation which her community, not yet surfeited with attention, showers upon her. Stories of suffering among the rural people of the mountainous sections and of the prairies, make one feel how selfish nurses are to remain indefinitely in the cities. However, a few nurses have heard the call from the lonely and often impassable districts and have gone to work and sometimes to stay on indefinitely where they are so much needed.

Mental Hygiene Nursing is that kind of nursing which is concerned with the mentally sick. The nurse works between the state hospital and the home in the interest of the patient who perhaps has a disease as certain of cure as if had a physical disease in the usual sense. The field of psychiatry, however, is so new that as yet few nurses have had

the training or experience to make their services of real value. This may be due to the fact that nurses have not realized until recently that this field is one in which they are so much needed.

In a very few states there are Mental Hygiene Societies supported by private funds which have experimented with social service for mental cases. It is beyond the experimental stage now and social service is known to have a definite place in the care of the insane.

The kind of service which a Mental Hygiene Society worker does is to urge early treatment for patients known to be in a delicate state of mental health. This is not an easy task to accomplish, for the relatives and friends, even more than the patient himself, do not realize what symptoms are indicative of a dangerous condition. What is more often the case, the family and the friends attach disgrace to a patient's going to an insane hospital and no amount of persuasion sometimes can convince them that a life-time of misery might be prevented by early treatment.

When a patient is discharged from a state hospital the nurse visits the home and prepares the family for his return. She also prepares the community, as far as possible, so that the patient may be kindly received on his return. The former way, as well as the one which in many localities still prevails, was to shun the patient and make him feel that he was different from those about him. This made it difficult for him to get work and to find associates, and as a result he often became discouraged and a relapse occurred.

Hourly or pay service nursing is still another type of public health nursing in a limited sense of the term. This form of nursing is an attempt to serve the middle class patients by giving them nursing care at cost. There is no hint of charity about it and on the other hand, it is done with no view of profit. It simply pays for itself. In Cleveland it is done by the Visiting Nurse Association, which is equipped either through its own staff or in conjunction with a nurses' registry to care for confinements and minor operations in the home, with follow-up care as required. Five dollars is the charge for confinements and operations, and for the after care the following rates are offered: 75 cents for the first hour or part thereof and 50 cents for each hour or part of hour thereafter. The nurse who gives free service in a needy case may be the nurse who also cares for the family well able to pay the full price. No distinction is made in quality of service. It has been shown that there is a demand for service removed from the charitable type.

Contagious disease nursing is done either by a special staff of nurses, or by nurses doing general nursing work. In the first case, a small group of nurses give their entire time to contagious cases, but there are

few cities where even a special staff gives adequate care to the sick. Door-step instruction has prevailed far more frequently than bedside care, which fact is to be regretted. When the work is done by a general staff, the nurses make the visits at the close of the day, so far as it can be arranged, and take precautions to safeguard the health of non-contagious disease patients. This subject needs our earnest attention until such time as science will show us how we can care for both contagious and non-contagious cases with the minimum of danger and the maximum of comfort to all concerned.

With this wide range of opportunity for service in the field of public health, one realizes how broad a training a nurse should have. In every specialized department there is more or less opportunity to test the nurse's professional ability, as well as her social vision, her sympathy and her ability to obtain coöperation with other organizations.

A danger which besets many in this field, however, is the tendency to let go the opportunity to be of service as a nurse. The pendulum in many instances has swung from one extreme, hand-service with no instruction, to the other extreme, instruction and no hand-service. There are instances when one may be given without the other, but this should be the exception and not the rule. In considering actual nursing care, it goes without saying that it should be of the best and according to the highest ideals given us in our hospital training, regardless of how poor or squalid the surroundings.

Every branch of public health nursing is rich in opportunities for spreading the gospel of health, which should be considered a privilege as well as a Christian duty.

Health instruction produces the best results for the most part when taught by means of demonstration. The best way to teach a young mother how to bathe her baby or to prepare the baby's food is by bathing the baby and modifying the milk. The best way of teaching ventilation is by looking about to see which windows can be opened without producing actual discomfort to the patient and the household. It may be necessary to let in very little fresh air at first, by placing a board under the lower sash, by tacking a cloth across the window or by some other means showing the family how the house as well as the patient's room can be kept comfortable and yet be well aired. We rather ruthlessly sometimes advise fresh air when the coal and clothing supply is already so low that it is hard to keep warm.

In all these special fields the same principles of social science apply. No member of a family, because of this or that disease can live unto himself apart from the household. So far as the family is concerned, someone is sick and something must be done. Neither can a family be

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apart from the community in which it lives, for what is a community but the sum total of its households? The health of the family and the community is no greater than the health of the weakest members.

The nurse's business is to increase the health-rate of the families in the community. She may be especially interested in one phase or another of the work, but in any case she must see her problem in relation to the problems of the entire family and the community, if she is to live up to her opportunity. Someone has written of the public health nurse—"The home—the community unit—is also the health unit and in direct proportion to the ignorance or knowledge of its inmates will our death rates rise or fall. Coercion must give place to coöperation and to accomplish this we must carry on preventive activities to the kitchens and nurseries—to the firesides of our people—to motherhood—and we must do this through the nurse."

## STORIES TOLD BY NURSES<sup>1</sup>

### THE SOLUTION OF FAMILY PROBLEMS BY COÖPERATION WITH OTHER AGENCIES<sup>1</sup>

By HARMINA STOKES

The Department of Health of the city of New York has an agreement with the Henry Street Nurses' Settlement by which all pulmonary tuberculosis patients in the department's care are turned over to the settlement for bedside care, when required. Hence it happened that on November 20, 1915, James C., an Irishman in the second stage of tuberculosis, was transferred to the nurse of the settlement in the district where he lived.

The nurse found the patient up and dressed for the first time in seven weeks, sitting by the kitchen fire. The windows were tightly closed and the air of the room heavy with clouds of tobacco smoke from a pipe the patient was smoking. Not the least outwardly disturbed by these conditions was the patient's wife, a middle-aged woman, obviously broken in health, who hastened to clear a chair for the nurse to sit down; a young girl depressed and frail looking, holding a fine lively baby boy of six months in her lap, and her little girl, pretty and dirty and half dressed, playing about the room. Such a house as it was; four rooms, three of which were almost dark, two of them without direct access to the fresh outside air. Dirt and disorder were everywhere.

The nurse was not ungraciously received, but the patient did not hesitate to say that she was not needed, as he had nothing the matter with his lungs and was going back to work in the City Park Department the next day. Two days later the nurse called, found the patient in bed, but still thinking of going to work and refusing any attention. He listened rather sullenly to instructions in regard to sanitary precautions. The nurse of the Health Department was consulted and it was decided that the patient be persuaded, if possible, to go to Seton Tuberculosis Hospital, as every effort so far to teach and control him had been unsuccessful and his presence had been a decided menace in the family. He did decide to go and arrangements were made at once; his wife and daughter saw him safely there, but to everyone's surprise he returned home by night fall, because the good sisters had threat-

<sup>1</sup>One of three Case Histories contributed by Miss Stokes to Session of the National Organization for Public Health Nursing, April 26, 1917, on "Some Practical Problems of Visiting Nurses in the Bed-side Care of Patients."

ened him with a bath! The settlement nurse notified the health department nurse that the patient would not accept bedside care, and as supervision was needed he should be under her more authoritative control.

Two weeks later Mrs. C. met the settlement nurse on the street and begged her to call and try to persuade her husband to return to the hospital. The ninety dollars contributed by the Park Department employees had been spent, the rent (sixteen dollars and fifty cents) was overdue and the baby was sick. The St. Vincent de Paul Society and interested friends in the Roman Catholic Church were contributing to the support through the Health Department and this, added to the six dollars and a half a week earned by the young woman's husband as a messenger, was tiding the family over. The old man was in bed and out, drinking all the whisky he could get, coughing and expectorating in any convenient place, keeping the windows closed and using the family dishes. The little girl was found about to drink from his glass. He was entirely unreasonable and the family hardly dared to remonstrate with him. The nurse found the baby quite sick and no doctor had seen him. Cleansing care was given, the windows were opened and the women directed. A physician from a nearby dispensary was called, but because she was a woman and a homeopathist the mother did not have any confidence in her. One could not blame the girl. She was only an adolescent, nineteen years old, and already the mother of two children. It was natural under the circumstances of youth, poverty and ignorance that she did not take her responsibilities as seriously as they should have been taken. Then, too, it was to be expected that she should consider her own opinion final. On her own responsibility she borrowed the money and took the baby to a doctor of her own choice. She dreaded having the baby bathed and did all she could to prevent it without being the least bit disagreeable about it. She could never be depended upon to have hot water and a warm room ready for the baby's mustard bath, and sometimes the nurse had to give the bath with the neighbor's assistance or even in the neighbor's home.

Contrary to the usual custom considered advisable, two nurses were working in the same home—one for the tuberculosis patient and the other for the baby. As it became daily more certain that a forcible removal of Mr. C. to the hospital was necessary, the Health Department nurse had to call and collect a specimen of sputum, which, should it prove to be positive, would make the removal justifiable. She went also with the purpose of warning the patient in as kind and firm a way as possible of what would happen if he did not obey her instructions at once. Both nurses and supervisors agreed that the next step was to

call upon the Charity Organization Society to help in starting the rehabilitation of the family, and this was done. On January 1 Mrs. C. had a sudden heart attack and as she would not go to the hospital the nurse from Henry Street cared for her. She called in a friendly physician of the Lutheran medical staff, who astonished everyone by a diagnosis of chronic pulmonary tuberculosis as well as endocarditis. This doctor's visit proved to be a turning point in the nurse's attempts to teach the young mother. It is interesting to tell that she was so much improved by the doctor's skill and genial personality that she forgot she already had a doctor of her own choice for the baby, and begged this doctor to examine the baby. He did so and diagnosed the trouble as bronchitis and probably whooping cough. He recommended a continuation of the treatment, especially the mustard baths, and from that time on the nurse's task grew easier.

The poor old man, in the meantime, had not changed his ways. Why should he? He had nothing wrong with his lungs. The habits of a life time are not so quickly changed. His sputum proved to be positive. One day a physician from the Health Department came with an ambulance and took the old man to the city hospital on Blackwell's Island. There was something pathetic in his childlike submission to authority and the sorrow of his family—in which there was a half hidden feeling of relief. After this a plan was made at once by the Charity Organization Society to move the family. Three bright, airy rooms were found across the street from a New York Diet Kitchen Milk Station and the family moved into them. Mrs. C.'s sputum was negative and she was better again. The baby began to thrive in his new home and so did his mother, who was receiving one or more quarts of milk a day from the Charity Organization Society. The nurse struggled hard to get the baby to the milk station against all opposition of the mother. The milk station nurse coöperated valiantly and finally his mother took him. One day as all was going well, the old man returned and was seen sleeping comfortably on a mattress on the floor. He was waiting transfer back to Seton Hospital, because his family could not bear to have him die on the Island. He stayed at home only a few days and went without any protest. He didn't stay there very long, for life was not as unrestricted in certain ways as on the Island, and so he returned to die there, and to enjoy as best he could what little life was left to him. Mrs. C.'s diagnosis of tuberculosis could not be definitely confirmed, but the Health Department nurse continued her visits and proved a firm friend of the family. The Henry Street nurse withdrew as soon as the baby was in the care of the milk station.

To briefly summarize the history:

The beginning of a reconstruction of the family situation was undertaken by five organizations, with the following contributions:

The Department of Health with its authority to enforce sanitary regulations, the Church and St. Vincent de Paul Society giving material relief, the Charity Organization Society planning the methods of procedure and making them financially possible, the Milk Station seeking to educate the mother, and the Henry Street Settlement nurse, with medical support, giving bedside care and working to train and teach the almost unteachable, and work with the other forces in improving conditions.

## NEWS NOTES

A NATIONAL EMERGENCY COMMITTEE ON NURSING was formed at an informal conference on June 4th, its membership to be composed of the following persons: M. Adelaide Nutting, Chairman; Ella Phillips Crandall, Secretary; Annie W. Goodrich, President, American Nurses Association; S. Lillian Clayton, President, National League of Nursing Education; Mary Beard, President, National Organization for Public Health Nursing; Jane A. Delano, Chairman, National Committee on Red Cross Nursing; Julia C. Lathrop, Chief, Federal Children's Bureau; Dr. Hermann M. Biggs, Prof. C.-E. A. Winslow, Dr. Winford H. Smith, Dr. S. S. Goldwater.

The purposes of the committee are stated as follows: Owing to the present emergencies created by the war situation this committee has been called together to devise the wisest methods of meeting the present problems connected with the care of the sick and injured in hospitals and homes; the educational problems of nursing; and for meeting extraordinary emergencies as from time to time they arise. Prior to the formation of this committee, Misses Wald, Nutting, Lathrop and Goodrich addressed a letter, of which the following is an abbreviation, to the deans of women's colleges and of co-educational colleges:

The national crisis brings an urgent call for the college trained woman, which we ask your help in meeting. The withdrawal of many skilled workers from a field which is never adequately supplied inevitably brings about a critical situation, and the effect upon our hospitals and training schools will be particularly disastrous in that those called away include very many of the superintendents and teachers who are needed to direct the teaching and training of future nurses. Not less disastrous will be the shortage in the public health field. Never was there greater need for the conservation of child life. Never was there greater need for the fullest enlightenment of all classes of society concerning hygiene and sanitation. No contribution to the solution of this problem can be made by the short popular courses in nursing now so widely offered and urged. Because of the extraordinary condition a number of representative schools of nursing have, in response to our request, agreed to admit college graduates under specially advantageous conditions. Credit for a full academic year will be given to such candidates, who bring satisfactory scientific and other preparation and meet the usual requirements of these schools of nursing. For women so prepared the course of training will be brought into a period of two years, exclusive of the brief term of preparatory work. It should be borne in mind that students in schools of nursing have usually no expense to meet for tuition, and that in all schools board and lodging, laundry and in some cases uniforms, are freely provided.

The committee is now preparing another letter giving fuller information, which will be addressed to each member of the graduating classes of these colleges. Other plans of similar sort are in process of formation and will be reported from time to time in the pages of the *QUARTERLY*.

THE LAKESIDE (CLEVELAND) UNIT OF THE AMERICAN RED CROSS left for France at the beginning of May, and has the distinction of being part of the first American military unit to reach Europe for active service. Miss Grace Allison, Superintendent of Nurses of Lakeside Hospital is in charge of the nursing staff, and Miss Harriet L. Leete, Superintendent of the Babies Dispensary and Hospital, Cleveland, is her assistant. The greater number of the nurses resigned positions of responsibility in order to go to France, and a considerable proportion were engaged in public health work. Our heart-felt good wishes go with them in their work of mercy and heroism.

THE NATIONAL CONFERENCE OF CHARITIES AND CORRECTION was held in Pittsburgh from June 6 to 13, and the program of the meetings was one of very unusual value. A meeting of particular interest was that on Social Problems of the War, presided over by Edward T. Devine. Dr. C.-E. A. Winslow was chairman of a section on Public Health, and it is interesting to note that the thread of health problems ran all through the sessions, amongst the speakers on specific health subjects being Miss Beard, Miss Lent and Miss Stewart (Pittsburgh), who spoke on public health nursing subjects. We had hoped to give some report of the meeting in this *QUARTERLY* and to publish one or two papers of especial interest, but it was not found practicable to obtain the material before this issue went to press.

THE DEPARTMENT OF PUBLIC HEALTH NURSING OF THE SCHOOL OF APPLIED SOCIAL SCIENCES OF WESTERN RESERVE UNIVERSITY held its graduation exercises on June 11 and five graduates of the course received certificates. Miss Edna L. Foley made an address on "The New Public Health Nurse," and Professor Cutler, Dean of the School of Applied Social Sciences, described the general system on which the course is conducted, and outlined further plans for the future. The certificates were presented by Dr. Charles F. Thwing, President of the University. The presentation was followed by a delightful social hour.

## BOOK REVIEWS AND BIBLIOGRAPHY

**SOCIAL DIAGNOSIS.** Mary E. Richmond, Director Charity Organization Department, Russell Sage Foundation. Author of *The Good Neighbor*, etc. Russell Sage Foundation, New York. Price \$2.00 net.

It is peculiarly fitting that after three papers on "The Nurse and The Social Worker," the opportunity should come to acknowledge *Social Diagnosis* by Mary Richmond, a book for which social workers have been eagerly waiting for over a dozen years. If it is mutual understanding of aim and method that makes for good team work, we wish that every social worker could read Miss Gardner's *Public Health Nursing* and every public health nurse Miss Richmond's *Social Diagnosis*.

The book gives in considerable detail the technique of investigations in social work, discusses the comparative value and use of various kinds of evidence, and gives valuable guidance in the comparison and interpretation of facts after they are gathered. Miss Richmond has assembled her material in scholarly and orderly fashion, with splendid summaries at the end of each chapter and a wealth of illustration from actual case records. She does not attempt to go into the subject of social treatment, but has set as her task the elucidation of diagnosis, consisting of investigation, comparison, inference and interpretation, all leading to diagnosis which in turn is the basis for treatment.

Every public health nurse has many opportunities to do real social work among her families, but many of us through pressure of time, and lack of study and understanding, have to do it in an amateur and snapshot way which we realize is not adequate. Even if no actual money relief is needed, careful study is none the less necessary before we can do justice to as delicate and intricate a thing as a "situation" in a home. We therefore welcome the first text book in the method of investigation, both for the public health nursing courses and for the private study of the thousands of nurses in active service.

BESSIE E. AMERMAN.

### BIBLIOGRAPHY

In April last the United States Department of Labor published two bulletins which are of particular interest at the present time, and, while of value to all public health nurses, should be of especial interest to those engaged in industrial welfare. The first (Bulletin No. 221) is entitled "Hours, Fatigue and Health in British Munition Factories;" the second (Bulletin No. 222) "Welfare Work in British Munition Factories;" both contain reprints of the memoranda of the British Health of Munition Workers Committee.

## IN MEMORIAM

HANNAH LEE WASHINGTON

With "Hallie" Washington—as her friends knew her—we have lost from our ranks a soldier who lived with the same gay, unconquerable courage, and who died fighting as gallantly as any of the legions of heroes who have served the cause of liberty on European battlefields.

Miss Washington died in Spokane, Washington, on January 15, 1917, after a long illness, tuberculosis, borne with extraordinary dignity and sweetness. It is curious and interesting to realize that as a descendant of the Washington family, her first and only constructive public health work was in Washington, D. C., and that her last years were spent in the distant state of Washington.

Hannah Lee Washington was born on the old estate belonging to her father, "Braddock," in Jefferson County, West Virginia, in 1871. Her father was a descendant of John Augustine Washington, youngest brother of George Washington, who married Hannah Lee, daughter of Richard Henry Lee, one of the signers of the Declaration of Independence. Her friends have always felt that in her frail body shone unabated the vigorous spirit of those ancestors who helped make the history of their country.

She entered the Johns Hopkins Hospital Training School in 1896 and graduated in 1899. Soon after, she became one of the staff of the Visiting Nurse Association of Baltimore, where for two years she did, as the writer well remembers, admirable and inspiring work. In 1902 she went to Washington as superintendent of the newly organized Visiting Nurse Association. For two years and a half she struggled valiantly and successfully with the problems and efforts of a young society. Her health, never very vigorous, broke down, and after a long leave of absence, she was unable to return. In 1905 she went to Colorado, and from there to Spokane, to join some members of her family.

The rest of her life has been spent in Washington, working whenever possible, with a courage and energy that never failed.

It must always be deeply regretted that her efforts to improve professional standards in the state in which her last years were passed, were too often ignored or unappreciated. Perhaps that was the great shadow of a life that under great physical stress and much discouragement always, "saw life steadily, and saw it whole." Her five years of public health work in its early stages of development stand out in the

memory of her friends, as having a remarkable vision of its possibilities, and independence of thought, and an extraordinarily happy way of dealing with immediate problems.

Now that the patient struggle of these last years is over, and she has gone gladly to her "Rendezvous with Death"—we can say in the words of another dead poet of the war,

Day shall clasp her in strong hands,  
And Night shall fold her in soft wings.

A. M. C.